UNIVERSITY OF KWAZULU-NATAL

INYUVESI YAKWAZULU-NATALI

SOCIO-CULTURAL FACTORS INFLUENCING INTIMATE PARTNER VIOLENCE AMONG SCHOOL-GOING YOUNG WOMEN (15−24 YEARS OLD) IN MAPUTO-CITY (MOZAMBIQUE)

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A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy (PhD), Public Health Medicine, College of Health Sciences, University of KwaZulu-Natal, Durban, South Africa

October 2021

Plagiarism

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DEDICATION

I dedicate this study to my lovely kids, Sasha and Allen.

ACKNOWLEDGEMENTS

This study could have never been possible without the grace of God, who gave me the breath, wisdom, and enough strength and resilience to pull me through to complete this doctoral research project.

- Undertaking this study on "Intimate partner violence among young women in Maputo, Mozambique" has been very challenging though interesting. I want to express my heartfelt gratitude to my Supervisors, Dr Nelisiwe Khuzwayo and Professor Myra Taylor, for their guidance, patience and support throughout my academic life and this study. Without your undeniable assistance and expertise, this project could not have been successful. Thank you very much.
- My most profound appreciation goes to the institutions that financially supported this study, to ISCISA, to the NICHE project and the College of Health Sciences at UKZN.
- I want to acknowledge and convey my sincerest appreciation to Mr Henário Sitoe, the Director of the NICHE project, for his expert financial management throughout the Project NICHE scholarship's compliance, and for the encouragement he gave and all the effort he made to provide the necessary resources throughout my studies. Gratitude is due to NICHE project coordinators Lenia Sitoe and Marlieke Bouwmans for their assistance towards the Project NICHE scholarship compliance.
- I am grateful to Dr Alexandre Manguele and Professor Fernando Vaz for the incentives and encouragement they gave to me to pursue this degree.
- I want to thank Mr Boikhutso Tlou for his technical expertise and guidance during the data analysis phase of my study and the inputs and encouragement he gave at all stages of this project.
- Sincere gratitude goes to my colleague Neusa Torres for the invaluable guidance and continuous support during this journey. I appreciated this.
- I want to acknowledge the Ministry of Health and the Ministry of Education, the Maputo city Secondary Schools, the Mkpfumu District Directorate, and the respective schools' headmasters for granting me permission and facilities to conduct this study in their area.
- I wish to thank the parents and students from the secondary Schools of Josina Machel, Francisco Manyanga and Polana, who agreed to participate in this study. Thanks are due to the research assistants for their support throughout the data collection period. I am also

grateful to the Guidance and Counselling teachers from the mentioned schools who were very supportive during the data collection phase.

- I am also grateful to the College of Health Sciences, the University of Kwazulu Natal, Instituto Superior de Ciências de Saúde and the Netherland Initiative for Capacity Development in Higher Education for funding this study.
- Finally, I wish to acknowledge the support from my colleagues and friends: Hlengiwe, Kabuyaya, Marta, Sara, Lénia, Érica, Sesaltina, Nórgia, Messias, Mauro, Henário, Ricardo Xavier, Hélder, Baptista, Neusa, Gerito, Verónica, Nazir for their encouragement and support. Great thanks to my parents, siblings, nephews and nieces, kids, and Godparents for their unconditional love throughout my study. You all kept me going during the difficult times of my study.

DEFINITIONS

Individual factors

These are biological and personal characteristics of women that increase the likelihood of becoming a victim of violence. This study included factors placed at an individual level in the socio-ecological model (1).

Intimate Partner Violence (IPV)

This includes an act of physical, sexual and psychological/emotional threats or such harm by a current or former spouse, boyfriend, dating partner or ongoing sexual partner (2). For this study, we consider the violence committed by a male partner against the female partner.

Psychological/emotional violence

This refers to verbal and non-verbal communication with the intent to harm the partner mentally or emotionally, including exerting control over the partner. This includes "Behavior intended to humiliate and control a partner in public or private, including expressive aggression (e.g., name-calling, humiliating, degrading, and acting angry in a way that seems dangerous); and coercive control "(2).

Religious Commitment

This study defines the degree to which a person considers that s/he self-adheres to spiritual values, beliefs, and practices and uses them in daily living. It is operationalized as a yes or no response.

Physical violence

This is defined as the intentional use of physical force with the potential for injury or harm, including scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, hair-pulling, slapping, punching, hitting, burning, use of a weapon against another person (2).

Sexual violence

It is defined as a sexual act that a partner commits without the freely given consent of the victim. "Physically forcing a partner to have sexual intercourse or acts that she found degrading or humiliating, harming her during sex or forcing her to have sex without protection, nonphysical pressured unwanted penetration; forcing or coercing a victim to engage in sexual acts with a third person" (2).

Socio-community factors

These refer to those factors included in the community and societal level in the socio-ecological model (1).

Socio-cultural factors

These are the beliefs, customs, practices and behaviors that exist within a population that is related to gender norms, roles and relations (3). In this study, the socio-cultural factors refer to the contextual factors associated with IPV in the study setting. They include the age of the women, whether the young women's head of the household was unemployed, the young women's lack of commitment to religion, the young women having an older and employed partner and the young women's beliefs about male dominance.

Victim

This person is the target of IPV. For this study, the victim is considered to be the female partner.

Youth refers to persons between the ages of 15−24 years (4).

Young people refer to individuals aged 10−24years (4).

Young women

This study refers to women aged 15 to 24 years.

LIST OF ABBREVIATIONS AND ACRONYMS

BREC- Biomedical Research Ethics Committee
CDC- Centre for Diseases Control
CEDAW- Convention for Elimination of all forms of Discrimination Against Women
CSS- Complete Secondary School
DHS- Demographic and Health Survey
FGD- Focus Group Discussion
GBV- Gender-Based Violence
HIV- Human Immunodeficiency Virus
HSSREC- Human Social Science Research Ethical Committee
ID- identification number
IPV- Intimate Partner Violence
ISCISA- Instituto Superior de Ciencias de Saúde
LMIC- Low and middle-income countries
LIC- Low-income countries
SADC- Southern Africa Development Community
SEF- Socio-Ecological Framework
SEM- Socio-Ecological Model
SES- Socio-Economic Status
SPSS- Statistical Package for Social Sciences
UNESCO- United Nations Educational Scientific and Cultural Organization
VAW- Violence Against Women
UKZN- University of KwaZulu Natal
WHO- World Health Organization

ABSTRACT

Background

Although there is increased awareness about intimate partner violence (IPV) since the 2013 WHO report, providing solutions to address the problem remains a concern. According to the WHO (2020), research investigating factors underpinning IPV among young women remains of particular importance since the prevalence around the world is still escalating. Sub-Saharan Africa (SSA) carries the heaviest burden of intimate partner violence (36.6% of the global estimates). The burden is skewed toward young women aged 15−24 (19% to 66%) and is a public health concern (2, 5).

Cultural and contextual geographical overlap of risk factors elevates the chances of early occurrence of IPV. Thus, the World Health Organization encourages integrated and contextual prevention programs to promote awareness and gender equality, targeting adolescents and young girls for effective interventions. However, the harmful social norms and the acceptance of the males' dominant role in society perpetuates gender inequality to the detriment of females.

Although the Mozambican constitution entrenches gender equality, these negative, harmful norms and the community acceptance of violence and male-dominant norms are upheld by society and place younger women in a subservient role and at increased risk of IPV (6-8). Cultural practices such as lobola, where the brides' families receive gifts and money, and in exchange, their daughter joins the husband's family, were reported as promoting violence. The rationale for this is that some families do not allow their daughters to divorce when their partners abuse them because of the stigma and the fact that they would need to return the acquired lobola (8, 9).

Although it is acceptable and normal for men to have more than one partner in some societies, this is likely to promote disharmony and lead to violence (6-8, 10-12). Further, with the current prevalence of epidemics such as HIV and other sexually transmitted infections, the risk of multiple sexual partners can affect the health outcomes of all women (13-15).

IPV is deeply entrenched in cultural practices and decision-making processes. Men make all the decisions concerning their relationship and women's sexual and reproductive health.

Prevention programs have been mainly addressed towards adult and ever married or cohabiting women. There is no available data quantifying the burden of IPV and the prevalence and contextual factors influencing intimate partner violence among younger women in Mozambique. Thus, the

prevention of IPV among this group is one of the main challenges regarding reducing the prevalence of IPV.

Purpose

The study aimed to determine the prevalence and investigate the socio-cultural factors influencing IPV among younger school-going women in the KaMpfumu district, Maputo city.

Objectives

- To conduct a scoping review of the evidence of socio-cultural factors influencing IPV among young women in SSA
- To explore individual and socio-community factors influencing IPV among school-going young women in KaMfhumu district, Maputo city
- To estimate the prevalence of physical, sexual and psychological violence among school-going young women in KaMfhumu district, Maputo city
- To identify contextual risk factors associated with IPV among young women in KaMphumu district, Maputo city
- To inform a model of a preventive intervention to target school-going young women in Maputo city

Methods

The study, which used mixed methods, employed an exploratory sequential design using both qualitative and quantitative methods. It was underpinned by the Social-Ecological Theory (1), based on the evidence that a range of interactive factors at the individual, relationship, community, and societal levels explain the risk of IPV.

Phase 1 was a scoping review study carried out to determine the extent to which studies on socio-cultural factors influencing IPV among young women (15−24 years) have been conducted. Further, it determined how well different geographic areas are represented and whether the methodologies used are sufficient to describe the prevalence and risk factors associated with IPV among young women in Sub-Saharan Africa. We used online databases to identify published studies. The Preferred Reporting Items for Systematic Review and Meta-Analysis guidelines by Arksey and O'Malley were used to select studies, and primary studies were assessed using the Mixed Method Appraisal Tool, version 2011. Thematic content analysis was used to summarize the findings of the scoping review.

Phase 2 of the study used an exploratory, descriptive qualitative study design. We used purposive sampling to enrol 66 participants. We held six focus group discussions, each comprising 10−12 female students in schools in the KaMpfumu district, to explore the study objectives. The data were analyzed using a thematic content analysis approach.

Phase 3 was a cross-sectional study conducted among younger women aged 15−24 years attending schools in the KaMpfumu district, which used a questionnaire to investigate the study objectives. We used a probability proportional random sampling strategy to recruit 431 participants. The data were collected using a self-administered questionnaire, informed by the exploratory study results and the combined questionnaire from the WHO Multi-country surveys of violence against women. Binary and multivariate logistic regression analyses were performed, investigating the association between IPV and the predictors. Odds ratio (OR) and 95% confidence interval (CI) were reported, and for statistically significant associations, $p<0.05$.

Results

The scoping review results revealed that the majority of publications, 8 (61.5%), reported cross-sectional studies, while 4 (31.5%) were qualitative studies. Using a customized quality assessment instrument, 12 (92.3%) studies achieved a “high” quality ranking with a score of 100%, and 7.7% of the studies achieved an “average” quality ranking with a score of 75%. The scoping review results show that while the quality of the studies is generally high, research on socio-cultural factors influencing IPV among young women would benefit from a careful selection of methods and reference standards, including direct measures of the violence affecting young women. Prospective cohort studies are required linking early exposure with individual, community and societal factors and detailing the abuse experienced from childhood, adolescence and youth.

The qualitative study results revealed four main themes that emerged from the data and included: 1) (Individual level), related to knowledge of young women about IPV through witnessing friends being physically abused by their partners, from friends sharing personal experiences of IPV and experiencing the accepting attitudes of their mothers toward IPV; The meanings that young women give to the occurrence of IPV viewed as a violation of the human rights of women; The alcohol use a contributing factor for IPV and the economic status of women leading to acceptance of IPV. 2) (Relationship level) related to the Influence of friends. 3) (Community level) related to religious beliefs that placed men at the head of the social order above women and 3) (societal level) related to factors promoting acceptance of IPV, and these included social acceptance of violence and the male

chauvinism; The recommendations advocated by the young women to prevent IPV, and these included the promotion of awareness about IPV and the use of support services for the victims and the need to create specific IPV counselling centres for young women to meet their needs and to allow the counsellors to screen for other potential sexual and reproductive problems which affect young women.

The quantitative results revealed that of the 413 participants, 248 (60%) (95% CI: 55.15-64.61) had experienced at least one form of IPV in their lifetime. This includes one act of psychological or sexual, or physical violence. Of the 293 participants who had had a partner in the previous 12 months, 186 (63.4%) (95% CI: 57.68-69.00) reported IPV in the 12 months before the data collection. Psychological violence was the predominant type of violence, with lifetime prevalence reported by 230 (55.7%) and over the previous 12 months, by 164 (55.9%) young women.

The risk of IPV was associated with young women lacking religious commitment (AOR, 1.596, 95% CI: 1.009–2.525, p=0.046) and if the head of the young women's household was unemployed (AOR, 1.642 95% CI: 1.044–2.584, p=0.032).

Conclusion

The prevalence of IPV in young women attending schools in Maputo is high. Those young women not committed to religion, young women whose head of the household was unemployed, young women with a much older and employed partner and young women's beliefs about male superiority emerged as important socio-cultural factors influencing IPV in the study setting. The findings thus confirmed the contextual gaps that may hinder programs aimed at preventing IPV among younger women. The results highlighted socio-ecological factors that interact at the individual, community and societal levels in fostering IPV risk.

Recommendations

This study highlights that the government's policies to reduce IPV should incorporate the contextual socio-cultural factors that emerged, and interventions need to consider a multilevel approach. The educational sector should also develop comprehensive programs that integrate socio-economic empowerment strategies to increase young women's autonomy to decide about their lives. There is also a need to address religious beliefs from their cultural perspectives in such programs and improve social interactions that promote violence-free relationships. Community development interventions to reduce IPV are required to ensure effective and supportive programs tackling gender-egalitarian norms, to safeguard the physical, sexual and emotional wellbeing of young women in Maputo city.

TABLE OF CONTENTS

FIGURES

TABLES

CHAPTER ONE

INTRODUCTION

1.1 Introduction and Background

It is of concern that despite the World Conference on Human Rights and the declaration on eliminating all forms of violence against women, intimate partner violence (IPV) against women worldwide continues to increase (16). Although there is increased awareness about intimate partner violence (IPV) since the 2013, WHO report, providing solutions to address the problem remains a concern (17).

The World Health Organization (WHO) estimates that one out of three women experience violence from their partners globally (2). Sub-Saharan Africa (SSA) carries the heaviest burden of IPV, accounting for about 36.6% of the global burden (2). Young women between the ages of 15−24 years bear a large share of the prevalence, ranging from 37.6%−65.5% (2).

The World Bank classify young people as individuals aged 10−24 years (4); however, the focus of this study are women aged 15 to 24 years. Globally, the number of young women is increasing. There are about 880 million females aged 15−24 years worldwide, who comprise 12% of the world's population (4). Mostly they live in developing countries, including countries from the SSA region where Mozambique is situated.

Young women are also the population group most affected by numerous inequalities leading them to be potentially vulnerable to violence, including IPV. It is estimated that 80% of young women aged 15−24 have not completed their secondary education in many settings of SSA due to gender inequalities, which give privilege to men to the detriment of women (18). Moreover, the high rate of unemployment affecting this group, which is estimated at 13.0%, decreases their autonomy in making important decisions about their lives (4). For example, around 80% of young women in SSA countries cannot decide about their health, limiting their access to health services and, therefore, perhaps, preventing IPV (18).

In SSA, although many young women may live in their parents' households and not in cohabiting relationships, they initiate sexual relationships early (5, 19-21).

494 The harmful social norms and the acceptance of the dominant role of men in society also perpetuate
495 gender inequality to the detriment of women (17, 22, 23). For instance, in many African societies,
496 male figures occupy senior positions in their families and communities and women are socialized to
497 accept the seniority of their male partners. They are required to comply (6, 12).
498 For example, although, according to local custom, a male can have more than one wife, this may
499 expose the female partners to poor physical and emotional health (12).
500
501 Young women in SSA are further affected by high-risk behaviours, including risky sexual behaviour
502 and violence, including IPV. Their dating older partners increase their vulnerability to IPV ((15, 24,
503 25). However, there are no structured interventions to prepare them before they start dating in most
504 SSA countries. They thus tend to imitate practices to which they have been exposed, such as IPV (26,
505 27).
506 The continuing practice of IPV in families and communities affects the socialization of young people
507 (15, 20). The gender roles and negative community norms that influence IPV require communities to
508 reflect and develop improved strategies for promoting norms that will benefit both sexes to eliminate
509 IPV.
510
511 The problem of IPV among young women is thus of concern. It deserves immediate attention since
512 delays in mitigating this problem may promote recurrence and a continuous cycle of IPV (13, 28, 29).
513 Such interventions to prevent IPV include eliminating all forms of violence against all women and
514 girls in public and private spheres and achieving gender equity by 2030 (30).
515
516 The Mozambican government is also committed to preventing IPV against women, protecting
517 women's rights, and enhancing gender equity (31, 32). However, despite all the efforts made, they do
518 not seem to target young women and produce the expected outcomes by reducing the prevalence of
519 IPV among young women (33). Thus, the young women are an affected group with a high prevalence
520 of IPV, which is estimated at around 47,8% among women aged 20−24 years and 36.7% among
521 women aged 15−19 years. In comparison, among the adult women above 24 years, the prevalence
522 ranged from 41.3% to 47.6% (34).
523
524 As in other settings, social norms and gender inequalities are behind the vulnerability of violence
525 against young women in Mozambique. A study conducted among young women aged 15−19 years
526 reported that the participants agreed that since men cannot control their sexual desires, therefore,

women must satisfy men's sexual desires at any time (10). Another study revealed that one in four women justified that men have a right to hit their partner in some circumstances. Those justifying violence were younger (15−24 years) and experiencing financial constraints (34).

Although the Mozambican constitution entrenches gender equality, these negative, harmful norms are upheld by society and place young women in a subservient role and at risk of IPV (35, 36). Furthermore, current evidence of effective interventions for preventing Gender-Based Violence (GBV) in adolescents and young adults in Low and Middle-Income Countries (LMIC) reinforces the need for inclusion of adolescents and young girls in prevention programs to attain educational and economic empowerment to raise their awareness and reduce the gender inequalities leading young women to IPV (19).

A scoping review was thus undertaken to understand the gaps in available information for this target group of young women of 15−24 years in this specific setting where the burden is escalating (17). The research on socio-cultural factors influencing IPV among young women did not cover Mozambique, which has had a different history from many other SSA countries (34). This movement highlights the urgent need for comprehensive contextual programmes designed to prevent the early occurrence and reduce the prevalence of IPV among young women.

However, Mozambique is still grappling with the search for the contextual factors responsible for the high levels of IPV in young women. This study was thus undertaken since there was a need to use different methods and reference standards from the review, including direct measures of the violence experienced by young women in Mozambique. Therefore, mapping the prevalence and the risk factors of IPV, particularly among young women, is critical for improving the implementation of the recommended preventive programs.

The current global threats imposed by the COVID-19 pandemic has exacerbated the negative social and economic effects on families and society (37, 38). Further, the limits imposed by the COVID-19 pandemic may have potential effects on the individual and collective mechanisms to seek health services, particularly sexual and reproductive health and perhaps to obtain help for IPV (39). The WHO reports on the effects of COVID-19 point to an increased number of reports of domestic violence, including IPV, across the world (39, 40).

559 This study investigated IPV among young women. The findings offer an opportunity to rethink the
560 additional strategies and adaptation on the programs required to prevent IPV during crises (41). This
561 requires continuing research to explore potential gender and social inequalities that may be
562 exacerbated under calamities such as COVID-19 and may potentially lead to violence, including IPV.

563

564 **1.2 Research problem**

565 Young women in Mozambique face IPV despite prevention efforts from the government to reduce
566 the risk of their victimization (42). The current estimates are from the National Demographic Health
567 Survey (NDHS) that included domestic violence in ever-married or cohabiting women aged 15−49.
568 The prevalence of IPV reported in young women aged 15−24 ranged from 36.6% to 47.8 % (34).

569

570 Young women in Mozambique are further affected by high-risk behaviours, including risky sexual
571 behaviour and violence, including IPV and their dating older and multiple partners, which increase
572 their vulnerability to IPV (12, 24).

573

574 Notwithstanding, women experiencing IPV are likely to have more transactional sex (43). With the
575 current prevalence of epidemics such as HIV, they might be at increased risk of IPV and HIV through
576 violent or undesirable sexual intercourse and through their reduced ability to negotiate condom use
577 (12).
578 For example, young women who want to use protective measures such as condoms and contraceptives
579 must get approval from their partners, who are not always willing to use such protective measures
580 (15).

581

582 The Mozambican NDHS (2011) report revealed that about 25% of women aged 15−24 had their first
583 sexual intercourse before the age of 15 and 80% before the age of 18 (14). Further, 1% of women
584 revealed they had more than one sexual partner in the 12 months before the survey, and 50% of these
585 women revealed non-use of condoms at the last sexual intercourse. In addition, 10% of women aged
586 15−19 had sexual intercourse with men ten years older (34).

587

588 The current data regarding HIV/AIDS in Mozambique estimated a prevalence of 6.9% among people
589 between the ages of 15−24. The women had a higher prevalence at 9.8% compared to 3.2% amongst
590 their male counterparts (44).

A study conducted by Germano (2014), aiming at describing the characteristics of partner and non-partner violence among university students in Mozambique, suggested that the risk factors for partner violence among the participants were associated with their young age, their single marital status, having more than one partner, the use of alcohol and their financial constraints (24).

Due to the Mozambican socio-cultural context and the risk factors constantly affecting young people (6-8), additional factors might increase young women's vulnerabilities to IPV. However, the prevention of IPV among this population is portrayed as the main challenge to reduce the prevalence of IPV for the following reasons:

Firstly, little is known about factors that contribute towards IPV in young women. Instead, research has been mainly focused on adult and ever-married women, whereas the prevalence in young women is a burden (34).

Previous studies undertaken in Mozambique include the National Demographic Survey, which had a section on domestic violence among the general population, only covered ever married or cohabiting women between the ages of 15−49 (34). Studies were undertaken on clinical samples in healthcare centres (45, 46).

A study targeted universities and secondary school students between the ages of 15 and 45 years. This latter study measured 12 months' prevalence of IPV and lifetime prevalence of non-partner violence, that is, violence from other sources (24).

It may be difficult to compare the prevalence data on IPV because previous studies used different methods.

For example, the national and clinical surveys considered women at risk as only ever-married/cohabiting women of reproductive age. The survey among university students considered currently partnered women. Thus, the method of collecting the data did not address the needs of young women in this key age group.

In our study, we considered all young women (15-24 years) who ever had an intimate partner from the age of 15 (47). This includes all those who currently have or those currently not having, but who ever had an intimate partner.

These previous studies did not clarify the prevalence and factors underpinning IPV in the specific group of secondary school-going young women (aged 15–24) in Maputo. As the capital city of Mozambique, Maputo draws migrants from many other parts of the country. It is an appropriate place to initiate targeted programs in schools to reduce IPV to work towards SDG 5 against gender violence. There is thus insufficient data in Mozambique on young women of 15–24 years.

Secondly, due to the community acceptance of violence and social norms accepting male dominance, their perceived risk of violence is often not understood (10). Thirdly, the policies, law enforcement reduction and prevention strategies are more focused and known for domestic violence in ever married or cohabiting women (31, 42, 48).

Understanding the prevalence and the contextual factors influencing IPV among young women in Mozambique is crucial to assist program managers in channelling resources where they can be effective. Therefore, our study is timely and pertinent considering its contribution to the research required for tailor-made interventions for the prevention and reduction of prevalence and to stop the cycle of IPV in women's lives.

Although there is increased awareness about IPV, providing solutions to address the problem remains a concern (17).
A recent study undertaken in South Africa among adolescent learners indicated a high prevalence of IPV among participants aged 17 to 20 compared to the youngest aged 13 to 14 years (21).
In a study that explored factors associated with young adulthood violence and intimate partner violence in Uganda, a high prevalence of IPV among 16−24 years was also reported (41).
Similarly, in a study that explored the trends in prevalence and risk factors associated with IPV among Zimbabwean women of reproductive age, the high prevalence among women aged 15−24 years was reported.
Data from the most recent studies obtained from the Demographic and Health surveys of 25 countries in sub-Saharan Africa (including Angola, Chad, Congo, Gabon, Benin, Burkina Faso, Cote D'lvoire, Gambia, Mali Comoros, Rwanda, Uganda, Malawi and Zambia, was published between 2010 and 2019, the prevalence of IPV among adolescents and young girls, varied between 19% and 10.1% and was significantly associated with pregnancy termination (29).

Further, evidence indicates young women were experiencing IPV in the city of Maputo, Mozambique (24, 34). However, it appears that there is insufficient evidence to enable preventative programs to be undertaken.

Although this cross-sectional design could not establish firm causal factors and therefore more longitudinal research is needed, this empirical study provides useful current information obtained through a reliable methodology for measures and associations. It makes recommendations as to how IPV among young Mozambican women can be reduced. Using the information obtained from this study, interventions can be developed based on the data. This offers opportunities to work with young women attending secondary schools to determine whether the protective variables are associated with reductions in IPV rates in young women.

1.3 Purpose and Objectives

Purpose

The study aimed to determine the prevalence and the socio-cultural factors influencing IPV among school-going young women in KaMpfumu district, Maputo city.

Objectives

- To conduct a scoping review of the evidence of socio-cultural factors influencing IPV among young women in SSA (Papers 1, 2)
- To explore individual and socio-community factors influencing IPV among school-going young women in KaMfhumu district, Maputo city (Paper 3)
- To estimate the prevalence of physical, sexual and psychological violence among school-going young women in KaMfhumu district, Maputo city (Paper 4)
- To identify contextual risk factors associated with IPV among school-going young women in KaMphumu district, Maputo city (Paper 4)
- To inform a model of preventive interventions addressing school-going young women in Maputo city (Papers 3,4)

1.4 Thesis structure

The thesis is presented in eight chapters. Below is the summary of the Chapters.

Chapter 1: Introduction

This chapter contextualizes the study. It provides background information about IPV and presents the problem statement and the justification for focusing on IPV amongst young women. It also provides the purpose and the objectives of the study.

Chapter 2: Literature Review

This chapter comprises current literature that informed the study. It provides a current overview of the literature on IPV, the prevalence and the impacts. It discusses the risk factors in the contextual setting of SSA and finally presents an overview of IPV in Mozambique.

Chapter 3: Methodology

This chapter focuses on the description of the methods of the study. It includes background information on the study design, study area, sample size, enrolment of the participants, data collection, management and analysis, storage of the data and quality of the data collected.

Chapter 4: Publication (Paper 1)

This chapter presents the study aimed to develop a protocol to describe the rationale and hypothesis and plan the methodology for the review of socio-cultural factors influencing IPV among young women in SSA. The manuscript that forms the chapter is titled: "Mapping evidence of socio-cultural factors in intimate partner violence among young women: a scoping review protocol". Published.

Chapter 5: Publication (Paper 2)

This chapter presents a scoping review study to scope and document evidence of socio-cultural factors influencing intimate partner violence among young women in SSA. The manuscript that forms the chapter is titled: "Evidence of socio-cultural factors influencing intimate partner violence among young women in Sub-Saharan Africa: A scoping review". Published.

Chapter 6: Manuscript 1 (Paper 3)

This chapter presents an exploratory study conducted to understand the contextual drivers of IPV amongst young women in the setting of Maputo, Mozambique. The manuscript reporting the study is titled "Intimate partner violence: Views and perspectives of young women at Maputo-city secondary schools, Mozambique". It is under review in the Sage Open Journal.

Chapter 7: Publication (Paper 4)

This chapter presents a cross-sectional study investigating the prevalence of IPV and the factors associated among school-going women aged 15−24 years in Maputo city. The manuscript that forms the chapter is titled: “Risk factors associated with a high prevalence of intimate partner violence amongst school-going young women (aged 15–24years) in Maputo, Mozambique”. Published.

Chapter 8: Synthesis

This chapter consolidates the findings from all the chapters demonstrating their interconnectedness and relevance to the thesis objectives.

Chapter 9: Conclusions and recommendations

This chapter provides general conclusions. It also indicates the policy implications arising from the study findings and presents recommendations for further studies.

Appendices

The appendices contain ethical approvals, letters of permission, consent forms, a focus group discussion guide and the questionnaire used for the survey (Portuguese and English).

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

Firstly, I present an overview of IPV against women from a global perspective, then a detailed review of the consequences of IPV. The risk factors for IPV are presented based on the theoretical model that assists in explaining the risks for IPV. Further, an overview of IPV in Mozambique based on the available literature is presented.

2.2 Intimate partner violence: a global overview

SIDA (2007) defines Gender-Based Violence (GBV) as Any harm or suffering perpetrated against a woman or girl, man or boy, and that has a negative impact on the physical, sexual or psychological health, development or development identity of the person. The cause of the violence is founded in gender-based power inequalities and gender-based discrimination (49). Since GBV takes on many forms and can occur throughout a person's life cycle, this study focuses on a form of GBV that is such harm or suffering perpetrated by an intimate male partner against a female partner.

The World Health Organization defines Intimate Partner Violence (IPV) as the phenomena of violent acts that include physical, sexual and psychological/emotional threats or such harm by a current or former intimate partner (50). IPV constitutes the most common form of violence that women experience, and according to the United Nations (2020), 85% of Violence Against Women (VAW) is perpetrated by their male partners (30).

An intimate partner was defined as any male partner with whom the young women have or ever had a romantic relationship that included sexual activities, either spouse/husband, boyfriend/dating partner, or ongoing sexual partner/occasional partner (51).

Worldwide statistics show that IPV is higher in the WHO South-East Asian region (37.7%), followed by the WHO Eastern Mediterranean region (37%) and WHO African regions (36.6%). However, the WHO America region (29.8%), the WHO European region (25.45%) and the WHO Western Pacific (24.6%) are less affected (WHO, 2013) (2).

Furthermore, IPV has been reported to exist among young women worldwide. The estimates range from 31.6% among women aged 20−24 and 29.4% among women aged 15−19 globally (2). The early occurrence of IPV has been highlighted by the scientific community as a subject for scientific discussion (5, 21, 29, 41).

The factors influencing IPV, its adverse effects on women's health/well-being, and the communities '/countries' economy are also a subject of scientific discussion worldwide (52). IPV against women is described as a form of power and control in which men exert their authority over the women with whom they are in a relationship.

Gender inequalities and gender norms privilege men's dominance over women, and attitudes such as accepting wife-beating and men's entitlement to sex, have been identified as major socio-cultural factors behind IPV (11, 53). These beliefs in male dominance are based on existing social norms, which are perceived to be informal rules derived from social systems that define acceptable behavior within a particular society (3, 54).

In communities such as African ones, where the cultural construction of masculinity is perceived as masculine superiority, such perceptions may explain the gender inequalities, conflicts, and partner violence within families and communities (15, 54-56).

In LMIC, most of which are SSA countries, the risk of IPV among young women increased if they had ever witnessed violence against their mother, their partners used alcohol, their attitudes justified wife-beating and sexual coercion, and they experienced economic constraints (5, 20, 57). Thus, prevention efforts should consider the role of gender norms in the specific setting and design of contextual preventive programs.

Since the international community acknowledged VAW as public health, social policy, and human rights' concern, it triggered actions resulting in a global movement and commitment to eliminate VAW, including IPV. Moreover, the 2013 United Nations Commission on the status of women focused on prevention and the elimination of all forms of VAW, including IPV.

Further, the Sustainable Development Goal (SDG) 5 aims specifically to promote gender equality and empower women as essential steps to address the elimination of IPV (30).

According to WHO (2009), establishing laws that condone IPV are also crucial for providing legal support and to increase protection for victims while enhancing the behavioral changing of social

norms, especially in the setting of SSA, where the community construction of and actual behaviors are underlined by social norms (54).

Despite the initiatives mentioned earlier, the burden and early occurrence of IPV in SSA are still concerning (17). This concern highlights the need to engage efforts and to address primary interventions to reduce their impact. Therefore, the WHO have produced guidelines to provide health and support for victims. These include multiple entry points and concerted, multi-sectorial responses that aim at promoting and preventing IPV in low resourced countries (58, 59).

Furthermore, the WHO considers it urgent to tackle IPV as a human rights' issue and an essential key point to protect women's sexual and reproductive health and reduce their poverty and promote economic development (49). Therefore, the effective strategies to end IPV may require that women be economically empowered and provided with knowledge and education to enhance their autonomy and ability to decide about their health (60).

However, to produce effective results, both boys and girls need to be involved in such programs to promote gender equity (20). It is also important to consider contextual political systems and how they can effectively prevent IPV against women (17). This will need actions to be integrated and contextualized through a multilevel approach (61). This includes a call for research sectors to produce and propose evidence-based preventive interventions.

Thus, this study is timely and pertinent since it will provide evidence-based information required to contribute to the contextual preventive efforts to reduce the prevalence of IPV among young women in Mozambique.

2.3 Risk factors of IPV

IPV is a common phenomenon, and it is mainly influenced by the factors interacting at different levels and includes the young age of women, discrepancies in the education level between partners, the low economic status of women, alcohol use, previous history of violence, including childhood violence or witnessing parents' violence, social norms of male dominance and the environmental and legal systems.

The young age of women

Research providing evidence on the age of the women and IPV suggests that being younger than a partner is a risk factor for IPV since the female younger partner may struggle to air her opinions about the relationship. Further, the older partner may expose the younger female partner to violence (9, 62-64). The higher prevalence of IPV among the youngest is a critical finding across studies and deserves prevention efforts.

Studies have hypothesized that the young age of women may reduce their ability to deal with the complexities and the dynamics of relationships and therefore increase their risk of IPV (14, 65, 66).

A study conducted in a rural area in South Africa estimated the prevalence of any IPV among adolescents' girls and young women aged 13 years to 14 years, 15 years to 16 years, and 17 years to 20 years was 10.8%, 17.7%, and 32.1%, respectively (21).

The age differences between partners were also reported predictors for IPV. If married to or in a relationship with a partner older than herself, a young woman may struggle to air her opinions about their relationship. Further, the more senior partner may expose the younger female partner to violence (21,23). Engaging in sex with older partners reinforces social norms within relationships that could be harmful since they may lead to low support of gender equity, sexual expectations and roles (24, 29, 41).

The low economic status of women

Several studies' findings suggest that women who are economically dependent and unable to meet their financial needs are at an increased risk of IPV and more likely to remain in a relationship with violence (63, 67).

In a study carried out among South African adolescent learners, the findings suggest that the risk of IPV increased among adolescents who were not receiving pocket money from their parents compared to those who were (20).

Similarly, a survey conducted in 31 countries, including South Africa and Tanzania, evaluating IPV and economic status among college students, revealed that the higher levels of IPV were associated with an inability to meet daily financial needs and being younger (68).

In a study conducted LMICs, including countries from SSA, the findings indicated that more prosperous and more empowered women generally reported less IPV (17, 19, 25).

A study conducted by Germano (2014), aiming at describing the characteristics of partner and non-partner violence among university students in Mozambique, suggested that the risk factors for partner violence among the participants were associated with their young age, their single marital status, having more than one partner, the use of alcohol and their financial constraints (24).

Considering the age and low economic status as factors associated with vulnerability to IPV, it needs to be regarded as a specific or contextual factor with potential variability across countries and settings.

Among school-going younger women at the initiation stage of their relationship, their financial dependence might reduce their likelihood of leaving a relationship if there is violence (20, 21, 24). Young women under such conditions accept the violence perpetrated by their partners, including having sex when they do not want to and performing other sexual activities (5, 21, 23, 41). This understanding emphasizes the public health burden of IPV and its rationale among young women experiencing financial constraints in a developing country such as Mozambique.

The prevailing socio-cultural and economic gaps may hinder the current interventions in preventing IPV among young women (41). Empowering young women and communities economically and promoting education in gender-egalitarian norms have a pivotal role in reducing the inequalities leading to IPV among young women in Mozambique.

Witnessing of violence during childhood

The findings from studies across different settings suggest that young women shape their behaviors as modelled by their families and friends. A study conducted in the USA setting assessing factors of IPV victimization among young women revealed that having witnessed father to mother violence during childhood was a predictor of IPV acceptance (69).

Children may also learn violent behavior from their parents or their parents' modelling behavior and might then imitate or replicate the behavior across their lives (20, 70). Moreover, the likelihood of experiencing IPV among women who have ever been exposed to violence in childhood, might be through the mechanism of their lacking in coping skills, which may lead them to engage in violent methods when resolving conflicts, rather than non-violent conflict resolution methods (41, 71).

876

877 ***Male dominant norms***

878 Gender inequalities have been linked to IPV (67). Considering the community and societal factors,
879 findings suggest that female victimization is more likely to occur in a setting where the women are
880 less educated. Their autonomy is low when society supports traditional norms of male dominance
881 (72-75).

882 Studies have also suggested that IPV is likely to occur where the society is in conflict, gender and
883 social inequalities, and weak rules of law and wide social acceptance of violence. For example, in a
884 South African study, the findings revealed that the factors associated with girls' experience of IPV
885 included childhood experiences of violence such as corporal punishment at home, school or
886 community, and growing up in a violent community (20, 57).

887 The cultural context and the existing harmful social norms in SSA also affect young women. They
888 may help explain the burden and recurrence of IPV among young women in this setting (8, 21). The
889 construction of masculinity has been recognized as another negative influence on IPV. Additional
890 studies suggest that the cultural construction of masculinity, perceived as masculine superiority, may
891 also contribute to gender inequalities, conflicts and partner violence within families and communities
892 (11, 41, 53).

893 In many traditional societies, beliefs about male superiority remain strong, and women's
894 empowerment has proved to be a slow process. The existing gender norms in families and
895 communities in the settings affect the socialization of young people. They may influence the
896 occurrence of IPV (6, 20, 23). Since women are socialized to accept and comply with the norms of
897 perceived male superiority, they might accept the violence perpetrated by their partners (6, 12, 15).

898 Gender norms that give privilege to men's dominance over women, the acceptance of wife-beating
899 and men's entitlement to sex have been identified as major socio-cultural factors underlying IPV (10,
900 23, 57).

901

902 ***Alcohol consumption by the male partner***

903 Widespread alcohol consumption and its connection with IPV has been in the spotlight of research in
904 many countries. The risk of IPV among males and females who have ever consumed alcohol is due

to the negative impact of alcohol consumption, since alcohol abuse is deemed to reduce one's sense of responsibility, and thus people engage in risky behaviours, including IPV (20, 24, 76-78).

Alcohol use by a male partner was related to attitudes of controlling behaviour (21). For example, it is hypothesized that men might persuade a female partner to consume alcohol to expect she will welcome sex and then use force if she does not agree to engage in sexual activities (72, 79). Widespread alcohol consumption and its connection with violence among young people have been in the spotlight of research in SSA and US settings.

It is thus crucial to tackle alcohol use and its association with violent attitudes when implementing IPV programmes among young people and, therefore, to teach young women to recognize and avoid engaging in such violent relationships (15, 24, 76, 77,78).

2.4 Impact of IPV

Health outcomes

The impact of IPV extends to individuals, families, communities and societies. Researchers have discussed the diverse sexual and adverse reproductive health conditions, mainly affecting young women due to their developmental anatomical and transitional biological characteristics, that predispose them to be more exposed to negative results from IPV (80, 81). This includes transmitted sexual infections, including infection with HIV, unwanted pregnancies mainly resulting in unsafe abortions, or babies' low birth weight, in the low use of contraceptives and even in experiencing pain during sexual intercourse (13, 29).

Moreover, women subjected to IPV are also at risk of acquiring mental disorders, such as depression, post-traumatic stress, eating disorders and even suicidal ideation (28). Injuries and even death have been reported due to the severe acts of physical and sexual abuse. Globally, the prevalence of injuries and deaths resulting from acts of IPV are reported at 42% and 38, respectively (82).

The literature reported investigations of other health outcomes among women exposed to IPV and pointed to increased risk of abdominal pain, gastrointestinal problems, neurological disorders, chronic pain, disability, anxiety and post-traumatic stress disorders (83). Non-communicable diseases such as hypertension, cancer and cardiovascular diseases were also reported (82).

In research comparing health outcomes among abused and non-abused women in South Africa, the findings revealed that abused women were more likely to report headaches, back pain, pelvic pain,

digestive problems, and loss of appetite, painful intercourse, urinary tract infection, sexually transmitted diseases, vaginal infection and bleeding compared to non-abused women (84).

Impact for Economy

The long-term consequences of IPV on women's health and society have been suggested as impacting their health status, resulting in poor quality of life, high use of health services, injury, and increased risk of illiteracy (4). Moreover, the lack of women's participation in society, often due to morbidity and mortality, leads to a reduced economy and an increase in poverty (85). Furthermore, victims of IPV are more likely to use justice, healthcare and law enforcement services than non-abused women. Therefore, the use of such services may result in high costs for the countries (86). Additionally, women exposed to IPV are more likely to take time off from childcare and household duties, resulting in lower work productivity and impacting the weak economy (86).

There is consensus that exposure of women to IPV is an important determinant of poor health in women and societies (60). In addition, the costs of IPV, where it is possible to estimate, such as in the United States, exceed $5.8 billion each year, of which nearly $4.1 billion is for direct medical and mental health care services (87) (66). Additionally, almost $0.9 billion is allocated in lost productivity from paid work and working in the household for victims of IPV. This is estimated at $0.9 billion in lifetime earnings of victims of intimate partner homicide (87) (66).

In the countries of South America, for example, the costs of IPV have been compared with the costs for primary education (49). For example, the World Bank Group Voice and Agency (2014) reported that in Peru, the economic costs for interpersonal violence are more than 3,5 % of the gross domestic product (GDP), and for primary education, less than 1,5% (87).

In SSA, economic factors have also been identified as the cause for concern, as interpersonal violence such as IPV in the SSA region contributes negatively to the economy. For example, the IPV is estimated by a Danish study to have reduced the GDP in SSA by around 15% compared to a 3% reduction of GDP in high-income countries (88).

2.5 Effective interventions implemented in SSA for IPV

In SSA, community-based interventions rather than individual approaches have been promising in preventing IPV (27). Evidence of interventions tested in SSA included economic incentives and change of harmful social norms.

The "IMAGE" is a microfinance program that is combined with an HIV and gender issues curriculum implemented in South Africa (89). The program found that IPV reduced with interventions combining education and economic empowerment. The violence experienced by women with their own income decreased by 55% (A0R = 0.45; 95% CI = 0.23, 0.91). There were also improvements in the women's ability to challenge the acceptance of violence and to leave the violent relationship (89).

The "Male Norms Initiative" (MNI) is an intervention focused on males (15–24 years old). The program combines group education and community engagement to address gender norms, social expectations, and responsibilities (90). The intervention aims to promote equitable gender norms and reduce the risk of adverse health outcomes associated with gender norm behaviors. Although the program is directed to males, this has been found to produce a statistically significant reduction in violence perpetration, lower risk of HIV and other STIs, which leads to healthier relationships (90).

The "SHARE" (Safe homes and respect for everyone) is a community-based intimate partner intervention using strategies from Raising Voices and Steppingstone programs (91). The program was implemented in Uganda, using an ecological framework to address factors of IPV at the individual, relationship, and societal levels, working in partnership with community residents, local leaders, and professionals to prevent and mitigate gender-based violence. Physical and sexual partner abuse was found to be significantly reduced after participation in the SHARE intervention (91).

Although the "SHARE" program has been designed to address the factors at multiple levels and the target on social norms, which also demonstrated reduction of IPV, however, the program focused on adults, not targeting the young people. There is a need to include young people in the intervention to prevent IPV at an early age.

"SASA", which means now in Kiswahili, is a community mobilization intervention developed to prevent violence and reduce HIV risk behaviors started by Raising Voices in Uganda (92). It has also been adapted in Botswana, Burundi, Ethiopia, Kenya, Malawi, Rwanda, South Sudan, Tanzania, Uganda, and Zambia. Evaluation studies have shown reduced attitudes of social acceptance of partner violence and acceptability of the right to refuse sex. The intervention was also associated with significant low acceptance of IPV among women and men (92). Further, men who participated in the

intervention reported a significantly low incidence of concurrent sexual partners in the past year than men who did not participate (0.57, 95% CI [0.36–0.91]. In addition, participants in the intervention reported low experience of physical and sexual partner abuse (92).

The "Steppingstone" intervention, which consisted of education regarding sexual health and risk behaviours, contraception, HIV, communication skills, and gender-based violence to both men and women, was initially implemented in Uganda. In South Africa, it has been adapted for adolescents and young adults ages 15–26 and showed promise in decreasing IPV. At 24 months of Steppingstone interventions, fewer men reported IPV perpetration than those in the control group (6% vs 10%, $p = 0.054$) (93).

A school-based curriculum program implemented in Keya, which aim to increase awareness of gender roles, norms and violence, was directed toward male high school students between 15–22 years old. Attitudes of males toward girls and women gender roles and norms improved after the intervention (94).

A school-based intervention with primary school girls aged 10-16 adolescent of both sexes in Kenya consisted of delivering a multicomponent curriculum that focused on promoting gender-equitable behavior with the boys and for the girls, implemented empowerment, gender relations, and self-defence training. A reduction in risk of sexual assault was estimated at 3.7 % decrease, $p = 0.03$ and 95 % CI = (0.4, 8.0), among the girls (95).

Understanding what programs work to prevent IPV among young women is essential. It will likely change the negative course of victimization across life and allow the young women to pursue healthy relationships with physical and mental integrity. However, while most IPV interventions have been successful for adults, some have failed to produce positive effects in young women in the context of SSA (19, 96).

The limited participation of both young men and young women in the design of the intervention and the lack of consideration of the specific context and specific characteristics of young people may be the reason (26). More research using different methods is needed to produce evidence-based information for interventions and programs that meet young women's needs and prevent and reduce IPV among young women.

2.6 IPV in Mozambique-an overview and a brief description of prevalence, factors associated and programs toward IPV prevention

The prevalence of IPV among young women and the associated factors are less documented in Mozambique. For instance, only one National Demographic Health Survey (NDHS) was conducted in 2011, including domestic violence issues in ever married or cohabiting partners, to obtain representative data for the country. This data included females and males aged 15−49.

The survey indicated that the prevalence of lifetime physical or sexual violence from a male partner against a female partner was 46% (34). The higher prevalence was in the age group of 20−24 years with a prevalence of 47.8%, followed by the age group of 15−19 years with a prevalence of 36.7% (14). Additionally, 29% had experienced emotional abuse, and 12% had sexual abuse. However, 18% of them had experienced physical or sexual abuse in the 12 months before the survey (34).

The study pointed to behaviors of partner control which included jealousy in 65% of cases and wanting to know where she was, reported by 29% of the women (34). The survey highlights protective factors and factors increasing victimization. This indicated that most women who experienced partner violence are residents in rural areas with many children. Moreover, women who reported more abuse reported that their partners were heavy alcohol users (34).

The survey indicated that women justify that men have the right to hit their spouses in some circumstances. However, women who justify violence are also the ones who experience more IPV than women who do not support the right of men to hit their wives. The latter women are better educated, living in urban areas and were employed (34). This group of women reported violence amongst family and friends, but none had reported such abuse to the authorities (34).

In the survey report, 13% of victims reported injuries, including harm, wound, pain, eye lesions, burning, and loss of teeth (34). There were, however, limitations encountered in assessing the disclosure and factors relating to IPV, as the survey was carried out in the household (34, 51). Thus, the real prevalence could be higher. Although there is limited information regarding IPV among young women in Mozambique, these results indicate the need for urgent intervention to prevent the recurrence of IPV.

2.6.1. Policies and programs regarding IPV in Mozambique

Although IPV in Mozambique has been an issue of concern to relatives, it has been considered a human rights violation and a public health concern (35).

The global efforts towards the platform of action (1995) and the World Movement of Women in 2000 generated a movement of civil society organizations and activists engaged in advocacy for a law against partner violence.

In the last ten years, the Mozambican government has demonstrated a growing commitment against VAW and towards protecting victims. Action has been taken concerning policies, laws, strategies, programs and specific international and national agreements.

At a global level, the Mozambican government has signed letters of understanding to ensure their commitment against all forms of discrimination against women. International agreements leading to human rights and gender equality include the Convention on the Elimination of All Types of Discrimination Against Woman (97), the Declaration of Gender Equality in Africa and the Declaration of Southern African Development Community for Gender and Development (98, 99), the African Letter of Human Rights (100) and the Southern African Development Community Gender and Development Protocol (101).

In Mozambique in particular, the declaration contributed to advocacy for the law on domestic violence against women, which aims to protect the women, victims of domestic violence (Lei da Violencia Domestica praticada contra a Mulher; Lei nº 9/2009 (35). Over the past years, the Mozambican national actions include the gender policy and implementation strategy (31, 32). The National Plan for Prevention and Combatting Gender-based Violence (102) and the National Plan for the Advancement of Women 2015−2019 (103).

The multi-sectoral mechanism for attending to women subjected to partner violence was approved in 2012 (104), the National Strategy for Prevention and Elimination of Premature Marriage 2015−2019 (105), and the Strategy of Integrating Gender in the Education Sector 2016−2020 (106). The gender issues are also integrated into critical areas of interventions and health promotion, such as the HIV/AIDS plan for 2015−2019 (107), the Strategy of Promotion of Sexual and Reproductive Health and Rights (108), the National Agenda for Research (109) and the 2015−2019 Government five-year programs (110).

Despite all the plans mentioned earlier, there is still limited evidence of outcomes from their implementation, and the pattern of gender violence reveals continuing gender disparities (33).

Moreover, the existing cultural practices such as initiation rituals, practices of payment for traditional marriage (lobola), and polygamy, as well as the culture of violence, which was inherited from the civil war, reinforce gender inequalities and social acceptance of violence and partner violence (111).

The report on the pattern of gender in Mozambique revealed that the significant challenge in the country is the implementation of national laws and regulations that protect the rights of women and girls in all sectors (33). There are laws, regulations, and strategies concerning gender equality in many sectors, there are few implementations, which results in continuing disparities of gender (33). Notwithstanding, the report suggested the need for government to strengthen the implementation of the approved policies, norms, and regulations on gender equality and the empowerment of women (33). Most importantly, according to the report, there is the need to create mechanisms and systems for monitoring and evaluation so that the gaps in implementing the approved laws and strategies are identified to make specific recommendations (33).

To date, little is known regarding available interventions in Mozambique to address IPV in young women and limited evidence of outcomes from their implementation (33). Further, there is no indication of policy analysis about the law on domestic violence (33). To date in Mozambique, the actual pattern of gender violence reveals continuing gender disparities reflecting the high prevalence of IPV among young women (24).

The current prevention programs on partner violence in Mozambique indicate collaboration with the educational sectors to promote gender equality. However, the high concerning prevalence of IPV among this specific population group indicates a gap among young women in schools regarding their skills to challenge male dominance norms and effectively prevent IPV (24).

This raises concern about the young women's low gender empowerment attitudes and indicates an urgent need for education on gender equality early in the school programs and the importance of involving both sexes for effective results (94).

There is a need to evaluate how current primary prevention interventions such as the promotion of gender equity and IPV awareness in schools can best be adapted by adding multi-level contextual approaches that reach young women in schools early (91, 95).

Changing gender norms regarding male dominance requires school-based and community-based initiatives to promote gender equity that may further enhance communal engagement and information dissemination channels (21, 95).

In Mozambique, the services to address IPV are available but are not specifically for young women (48). These are mainly based in health care centers to promote a multisectoral response to prevent GBV and integrate health, social work, justice, and police (48). The opportunity for young women in dating or occasional relationships or those initiating relationships and experiencing IPV to seek help may be limited (26).

In a study undertaken to evaluate the available mechanisms in Maputo to obtain assistance, the results indicated several factors influencing the victims against attending such services (112). Participants in that study felt that the providers lacked empathy. They also felt that providers in the different sectors providing services are not confident about dealing with the victims (112).

The professionals delivering this service who were interviewed during the study revealed their lack of training about GBV and the lack of coordination within the sectors about their different roles. These factors influenced their ability to provide and deliver adequate assistance to the victims of IPV (112).

Since there are services available specifically to address adolescents' and young people's sexual and reproductive health, this provides an opportunity that should be grasped to extend the awareness, prevention and support programs to prevent IPV in young women (26). Training programs to strengthen the skills of the providers in such services should be prioritized. Therefore, concerted and improved awareness campaigns involving communities and advertising the available services would help young women reach the counselling centres and contribute to preventing IPV.

One study aiming at evaluating the characteristics of partner violence among university students aged 15−45 in Mozambique revealed that the risk of IPV among the participants was increased by factors such as males having more than one sexual partner and the female partner is younger and having experienced financial constraints (24).

Additionally, a qualitative study aimed at evaluating a multispectral response on Gender-Based Violence revealed that the participants comprising a group aged 15−19 years agreed that women must satisfy men's sexual desires at any time (10).

The consideration of age and low economic status as factors associated with vulnerability to IPV needs to be considered as a specific or contextual factor with potential variability across countries and settings. Among younger women, who are at the initiation stage of their relationship, their financial dependence might reduce their likelihood of leaving a relationship if there is violence (24).

Young women under such conditions accept the violence perpetrated by their partners, including having sex when they do not want to and performing other sexual activities (12, 24).

This understanding emphasizes the public health burden of IPV and its rationale among young women experiencing financial constraints in a developing country such as Mozambique.

These results reveal critical socio-cultural and economic gaps that may hinder the current interventions. Interventions can be developed based on the data and offer opportunities to work with young women attending secondary schools, to determine whether programs that address the protective variables are associated with reductions in IPV rates in young women (21).

There is an indication of an initiative aimed at improving women's economic and financial status in Mozambique, through the promotion of entrepreneurship and employment opportunities, as an element of the 2030 Sustainable Development Agenda. However, the reported "National Program for women's economic empower" was only launched recently in 2019. It prioritizes illiterate women from rural areas. It is not addressing the needs of school-going young women (113).

There is a need for specific prevention programs to improve the economic circumstances of young women in schools (89).

Promoting greater awareness of Gender-Based Violence, empowering young women and communities economically and fostering education in gender-egalitarian norms still have a pivotal role in reducing the inequalities leading to IPV among young women in Mozambique.

To date, there is no available evidence of the implementation of specific interventions to address IPV among young women in Mozambique. Hence the country is still grappling with practical strategies to reach the 2030 goals.

From the high prevalence of IPV reported in this study, the policymakers and program managers need to use the findings of this study to re-assess how such intervention programs can be improved and new measures introduced to reduce the prevalence of IPV. The study emphasizes the need to develop and implement interventions early in young women attending schools and consider a socio-ecological model to address the contextual factors at different levels, including the individual, community, and societal.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This study employed a mixed-methods exploratory sequential design, including both qualitative and quantitative approaches (114).

As stated by Creswell (2017), a mixed-methods study contributes to the understanding of the interactions of factors while allowing the researchers to integrate and contextualize the information obtained from the different approaches (114).

There were three phases to the study. Phase 1 initiated a scoping review. Phase 2 comprised the data collection for the qualitative study. Phase 3 provided the quantitative data where the young women self-completed the questionnaire.

Before initiating the data collection, we carried out a scoping review to determine the extent to which studies on socio-cultural factors influencing IPV among young women have been conducted in SSA. To do this, it was necessary, a priori, to develop a protocol for such a review to enable us to describe the rationale and hypothesis and plan the methodology for the review of socio-cultural factors influencing IPV among young women in SSA.

The paper published in “Systematic Reviews” is presented below:

Maguele and Khuzwayo *Systematic Reviews* (2019) 8:312
https://doi.org/10.1186/s13643-019-1234-y

Systematic Reviews

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Mapping evidence of socio-cultural factors in intimate partner violence among young women: a scoping review protocol

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Abstract

Background: Intimate partner violence among young women continues to be a worldwide concern. Globally, a considerable number of studies reported numerous factors that influence intimate partner violence among the young. The proposed scoping review aims to map available evidence of socio-cultural factors influencing intimate partner violence among young women.

Methods: We will conduct a scoping review to explore, describe and map literature on socio-cultural factors influencing intimate partner violence among young women. The search strategy for this scoping review study will involve electronic databases including PubMed, Web of Knowledge, Science Direct, EBSCOHost (PubMed, CINAHL with Full Text, MEDLINE), Google Scholar, BioMed Central and World Health Organization library. Articles will also be searched through the "Cited by" search as well as citations included in the reference lists of included articles. Keyword searches will be used, and two independent reviewers will be screening titles, abstracts and full articles; where there are disputes between the two reviewers, a third reviewer will intervene. Thematic analysis will be employed to present the narrative account of the review.

Discussion: Understanding socio-cultural factors influencing intimate partner violence among young women is critical. This will enable researchers to map existing literature, map research gaps and guide future research.

Systematic review registration: PROSPERO (CRD42018116463)

Keywords: Intimate partner violence, Violence against women, Socio-cultural factors, Dating violence, Domestic violence

Background

Intimate partner violence (IPV) as defined by the World Health Organization (WHO) is a global phenomenon of violent acts that include physical, sexual and psychological/emotional abuse by a current or former intimate partner [1]. The WHO estimates that one in three (>30%) women experience violence from their partners globally, and the region of Sub-Saharan Africa (SSA) has shown higher prevalence where the statistics point to 36.6% [2, 3].

IPV among young women have been the subject of intense debate within the scientific community. Worldwide, IPV among ever-partnered young women aged 20–24 years was estimated to be around 31.6% and 29.4% among women aged 15–24 years in 2013 [4]. Of concern is the early exposure of young women to IPV since they are in the transitional stages of development [3, 5].

There are numerous factors influencing IPV among young women including HIV-positive status, level of education, economic status [6], alcohol abuse and socio-cultural factors [7]. There is a consensus among social scientists that young women who are subjected to IPV are more likely to acquire negative health outcomes including unwanted pregnancy, abortion, sexually transmitted infections including HIV, injuries or being murdered [8]. While factors influencing IPV among women are well documented, it is particularly important to understand socio-cultural factors influencing IPV

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among young women. Knowing that this is potencially the group of population with other risk factors including the risk of IPV, therefore the impact of IPV could be relatevely higher [5, 9]. Socio-cultural factors are beliefs, customs and practices within cultures and societies that affect the thoughts, feelings and behaviours of the community members [10]. Although socio-cultural factors influencing IPV are evident among older women, there are fewer studies focusing on younger women [7].

This information will be vital for researchers, governments and non-governmental organizations for the development of context-based primary interventions and policies. Further, the information generated from this review will benefit health authorities, health care workers, academics and general public. It will also be useful for educational purposes.

Therefore, this scoping review seeks to:

❖ Map existing types of socio-cultural factors influencing IPV among young women in Sub-Saharan Africa

❖ Map the extent in which socio-cultural factors promote IPV victimization of young women

❖ Determine the nature and quality of studies reporting evidence of socio-cultural factors on the intimate partner violence among young women

The findings from this review will enable the researchers to examine the extent, range and nature of research activity on IPV and socio-cultural factors among young women in Sub-Saharan Africa. The findings will also enable the researchers to identify and describe the context in which young women experience IPV as well as the main reasons for it.

Methodology

The current scoping review protocol is registered and published in PROSPERO, an international prospective register for systematic reviews under the following registration number: CRD42018116463.

The framework adopted for conducting the proposed review is by Arksey and O'Malley [11]. Briefly, the framework involves (i) identifying the research question, (ii) identifying relevant studies, (iii) study selection, (iv) charting the data and (v) collating, summarizing and reporting the results. This scoping review will include quality appraisal of studies.

Identifying the research question

What is the available evidence of socio-cultural factors in IPV among young women? The research sub-questions are:

1. Is there evidence of types of socio-cultural practices on IPV among young women in Sub-Saharan Africa?
2. Is there evidence that shows that socio-cultural factors contribute to IPV victimization among young women in Sub-Saharan Africa?
3. Is there evidence of the nature and quality of the studies reporting evidence of socio-cultural factors on IPV among young women in Sub-Saharan Africa?

Eligibility Criteria

The study will use an amended PICOS (Population, Intervention, Comparison, Outcomes and Study setting) framework to determine the eligibility of the research questions (Table 1).

Inclusion criteria

We will include

- Studies that show evidence on socio-cultural factors on IPV
- Studies that show evidence of intervention on IPV
- Studies that include the following outcomes: IPV, socio-cultural factors, morbidity/mortality and health effects of IPV
- Studies done in SSA

Exclusion criteria

We will exclude

- Studies reporting evidence of IPV among women under the age of 15 and women above the age of 24
- Studies that were published before 2008
- Studies on non-partner intimate violence
- Studies evidencing intervention on non-male intimate partner violence against women

Identifying relevant studies

Primary research articles published in peer-reviewed journals, review articles and grey literature that addresses the main research question will be included in this study. All study designs will be included in this review. Databases that the study will use to source literature include PubMed, CINAHL with Full Text, Health Sources MEDLINE, World Health Organization (WHO) and governmental websites which would be searched for policies and reports. This study will also use reference lists and existing networks such as organizations and conferences to source

Table 1 PICOS framework

Criteria	Determinants
Population	Young women aged 15–24 experiencing IPV
Intervention	Socio-cultural factors, intimate partner violence
Comparison	N/A
Outcomes	Intimate partner violence, socio-cultural factors
Study setting	Sub-Saharan Africa

1193

Table 2 Database search record

Date of search	Search engine	Keyword search	Number of articles found	Number of articles eligible

relevant literature. The search terms will include "Intimate partner violence", "Factors influencing intimate partner violence", "socio-cultural factors on the intimate partner violence", "dating violence", and "domestic violence".

This review will search studies that were published in any language; by not restricting languages of publications, all languages will thus be included.

The search strategy will be first piloted to determine the validity and reliability of the criteria of the study selection (Table 2). The pilot search results are presented in Appendix 1 (Table 4). The engine used is the MEDLINE database via EBSCOHost using the MeSH terms for searching.

Study selection

The study will conduct a comprehensive title screening by searching and uploading all literature search results on Endnote X7 software (Fig. 1). All the studies that do not address the research questions will be excluded together with all the duplicates. The reviewers will seek assistance from the UKZN library services for articles that are difficult to find. The reviewers will also contact authors to request full copies of the included articles that are not available via the databases and UKZN library. The final Endnote database will be shared among the review team for abstract screening; at this stage, two independent reviewers will screen the abstracts and full articles, with guidance from the inclusion criteria. Copies of full articles for eligible studies will be obtained and maintained for data extraction.

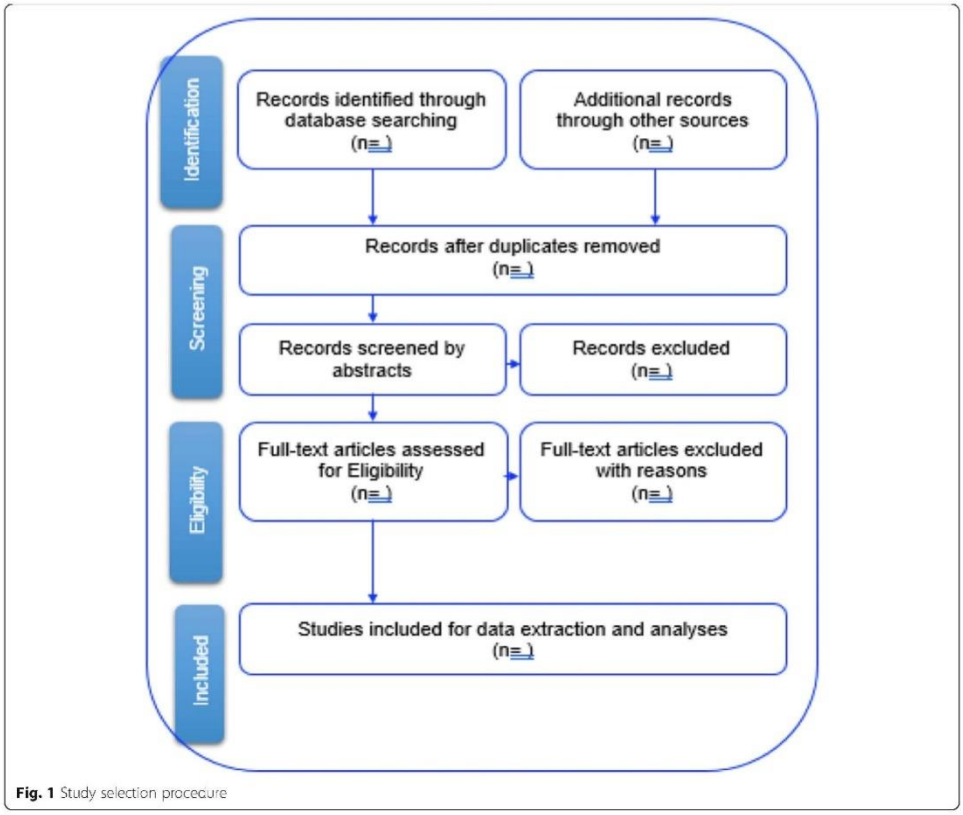

Fig. 1 Study selection procedure

Table 3 Data charting form

Author and date
Study design
Study setting
Population
Overage age
Sample size
Aims
Interventions
Outcomes
Key findings
Conclusion
Comments

Charting the data

The researchers will use a standardized data extraction sheet (Appendix 2, Table 5). The sheet will include bibliographic details, study design, number of participants, intervention, study setting, significant findings and conclusions for the primary and the secondary outcomes of the intervention (Table 3).

Collating, summarizing and reporting the results

The researchers will present a narrative account of the findings from the existing literature through a thematic content analysis of the extracted literature. The themes will be structured around the following interned outcomes which will be coded by all authors independently: socio-cultural, economic and behavioural factors, and experiences and reasons for acceptance of IPV. The emerging theme will also be reported. In aiding the thematic analysis, NVivo version 10 shall be used. The subsequent processes will be followed:

Coding
Categorize codes into major themes
Build theme-related themes (cut-and-paste technique)
Display data
Identify patterns in the data and identify sub-themes
Summarize

Quality assessment

Authors will interrogate the resulting themes and critically examine their relationship to the research questions. Authors will also scrutinize the meanings of the findings as they relate to the overall aim of the study and the implications for future research. A quality appraisal tool which focuses on the study methods, the Mixed Method Quality Appraisal Tool (MMAT), version 2011, will be used [12]. The tool will be used to examine the quality of an article looking at the following aspects: the appropriateness of the aim of the study, adequacy and methodology, study design, participant recruitment, data collection, data analysis, presentation of findings, authors' discussions and conclusions.

Discussion

The scoping review will be conducted as a first part of the study focusing on socio-cultural factors influencing IPVAYW in Mozambique. This scoping review aims to map evidence of socio-cultural factors in IPV among young women in SSA. The findings of this review will identify the extent to which socio-cultural factors among young women influence IPV. The purpose is to establish the extent of existing research on socio-cultural factors on IPV in SSA. Although studies on factors of IPV are taking place in these countries [7], there is still a scarcity of evidence on types of socio-cultural factors on the IPVAYW [1, 10]. The researchers will limit the research to include published studies from 2008 to 2019. A 10-year literature search is more likely to yield a comprehensive and balanced account of previous and current research in the area and to capture past as well as emerging perspectives on interventions on socio-cultural factors on IPV. This review will exclude studies that report evidence on non-partner intimate violence, as the focus is on intimate partner violence. The researchers therefore anticipate finding relevant literature on IPV in SSA. The results will provide documented evidence on socio-cultural factors on the IPVAYW and will help identify requirement priorities for primary research in this area. Due to how this study proposes to guide future research, the dissemination plans include presentations on public health institutions, local stakeholders, conference presentations and publication in journals. The review will also identify priorities for primary research and future research.

Appendix 1

Table 4 Results of the pilot search

Date of search	Search engine used	Keyword searched	Number of publications retrieved
8 May 2019	MEDLINE via EBSCOHost	("intimate partner violence") AND ("sociocultural factors") AND ("dating violence") AND ("violence against Human") AND ("domestic violence") AND ("Young women") AND ("Sub Saharan Africa") Published date: 2008 Jan 1 to 2019 Dec 31 Source types: academic journals	7570

Further, a scoping review was undertaken and to be included, studies needed to have been published between 2008 and 2019 and reporting evidence of the IPV in adult women, which included women aged 15–24 years.

A Summary characteristic of included articles is presented in table 1.

Table 1. Summary characteristics of included articles

Summary characteristics of included articles (n=13)	
Articles	**Number (% of total studies)**
Publication year	
2008-2011	4 (30.8)
2012-2015	6 (46.2)
2016-2019	3 (23)
Location	
South Africa	2 (15.4)
Kenya	3 (23)
Nigeria	2 (15.4)
Tanzania	2 (15.4)
Mali	1 (7.7)
Botswana	1 (7.7)
Rwanda	1 (7.7)
Togo	1 (7.7)
Setting: Urban versus rural	
Urban settings	4 (30.8)
Rural settings	3 (23)
Both urban and rural settings	6 (46.2)
Setting-Sector	
Colleges	1 (7.7)
Healthcare centre	4 (30.8)
Households	7 (53.8)
Services support centre	1 (7.7)
Design	
Cross-sectional studies	8 (61.5)
Qualitative studies	4 (30.8)
Longitudinal	1 (7.7)
Collection of data (methods)	
Questionnaires	9 (69.3)
Interviews	3 (23)
Focus group discussion	1 (7.7)
Topics investigated	
Prevalence and factors predicting IPV	7 (53.8)
Meanings and factors influencing IPV	4 (30.8)
Health consequences of IPV	2 (15.4)

This study allowed us to map the existing literature, research gaps and to guide the subsequent research methods applied in this study on socio-cultural factors influencing IPV among young women in Mozambique (Phase 1).

Following this scoping review, we undertook the qualitative study consisting of an exploration of young women's views, dynamics, and perspectives about the phenomena of IPV. This identified issues about IPV from the perspective of young women and the meanings and interpretations that they give to the phenomena of IPV. We used an exploratory approach at the first stage, where we conducted focus group discussions (FGDs) to develop a better understanding of the factors influencing IPV from the perspectives of the young women (Phase 2) (114).

The findings from this qualitative study were used to refine the questionnaire employed at the quantitative stage of the study consisting of a survey (Phase 3) (115-117).
This survey investigated the prevalence and the risk factors of IPV among young women in Maputo city. Conducting the quantitative study was the second stage of the data collection. This benefitted from the findings from the qualitative study since we were able to measure the contextual variables that emerged from the analysis of the themes of the qualitative study 114).

We then triangulated the findings of the two studies in the intermediate phase of the study. The study benefitted from both approaches since the qualitative findings provided a general understanding of the research problem. The quantitative findings explained the factors associated with IPV by providing the statistically significant variables (114, 116).
This allowed us to generate a more comprehensive picture of the nature of the problem and the contextual socio-cultural factors influencing IPV among young women in Maputo city. This also had the advantage of allowing the researcher to generalize the findings to other population groups (116).

3.2 Theoretical framework guiding the study

Inter-relationship between levels

A theoretical framework underpinning this study was required to examine the multiple levels of IPV factors, which was adapted from the socio-ecological model (1).
Knowing that the model considers the complex interplay between individual, relationship, community, and societal factors, through the overlapping of the levels, the model explains how factors at one level influence factors at another level and, therefore, the need to act across the four levels of

the model simultaneously when implementing the prevention strategies (118, 119). A diagrammatic representation of factors within cycles in cycles may best represent the model (figure 1).

The Individual level

Identifies biological and personal history factors that shape a persons' response to the microsystem and exosystem stressors that increase the likelihood of becoming a victim or perpetrator of violence. Some of these factors are age, education, income, substance and alcohol use, children history of abuse. Prevention strategies at this level promote attitudes, beliefs, and behaviors that prevent violence. Specific approaches may include conflict resolution and life skills training (94, 95).

The relationship level (microsystem)

Refers to interactions in which a person engages with others. This examines close relationships that may increase the risk of experiencing violence as a victim or perpetrator and the intermediate context of abuse. A person's closest social circle-peers, partners, and family members-influences their behavior and contribute to their experience. Prevention strategies at this level may include parenting or family-focused prevention programs and mentoring and peer programs designed to strengthen problem-solving skills and promote healthy relationships (90).

The Community level (Exosystem)

Explores the settings, such as schools, workplaces, and neighbourhoods, in which social relationships occur and seeks to identify the characteristics of these settings associated with becoming victims or perpetrators of violence. Prevention strategies at this level impact the social and physical environment. For example, by reducing social isolation, improving economic and housing opportunities in neighbourhoods, and the processes, policies, and social environment within the school and workplace settings (90, 91).

The societal level (macrosystem)

looks at the broad societal factors that help create a climate in which violence is encouraged or inhibited. These factors include social and cultural norms that support violence as an acceptable way to resolve conflicts. Other prominent societal factors include the health, economic, educational and social policies that help maintain economic or social inequalities between groups (91).

How has this model been used in previous IPV research

In understanding socio-cultural factors that influence IPV against young women, a study examined the association of social-ecological factors with IPV. The findings suggested that IPV was associated with diverse intrapersonal (depression), interpersonal (childhood abuse, sexual relationship power) and community (adolescent sexual reproductive health stigma, food insecurity). This calls for a multi-level approach to address social, economic and cultural gender-based inequities that affect persons and communities when implementing prevention programs (41).

A cross-sectional study evaluated the prevalence and associated factors of IPV among adolescents using a socio-ecological framework considered IPV a consequence of a complex combination of individual, relationship and societal factors (5).

The framework considered factors that operated at different levels and included in the analysis whether the woman's or her partner's mother was beaten or both, whether the partner was physically, and the woman sexually abused during childhood or both and whether the woman and her partners have secondary education or both. The woman's household status was relative to her partner, her attitude towards IPV, the woman's and her partner's heavy drinking and the woman's marital status. It also examined the effect of a woman having children from more than one relationship, the partner having concurrent relationships or being involved in fights outside the home in the last year, and if the woman's first sex was wanted, unwanted or forced, the couple's frequency of quarrel and existing controlling behavior (5).

The factors significantly associated with IPV included the young age of the women, witnessing violence against the mother, the partner's heavy drinking and involvement in fights, the women's experience of unwanted first sex, the frequent quarrels and the partner's controlling behavior (5). However, due to the study's cross-sectional nature, caution is needed when interpreting the causal factors (5).

What are some of the pitfalls of this framework identified in scholarship, and how does this thesis circumvent these

The analysis of risk factors using the socio-ecological model could help to suggest specific interventions to address the contextual factors emerging from the study.

Former theories that attempted to explain IPV tended to emphasize individual and social factors with little emphasis on the complex level of multiple factors in the micro and macro systems (119). Although some theories have tried to explain the men's perpetration of abuse, they have limitations

in explaining the women's victimization and to explain why some men do not inflict violence against women (119).

Although most of the earlier theories can explain the violence perpetrated by men against women, they fail to explain why the females are target victims and why some men do not perpetrate violence against females (119). As a result of the limitation of these previous theories to explain the variety of factors that may increase the risk of women becoming victims of violence and where man is the perpetrator, there was the need for an integrated approach to explaining the origin of violence (1).

Therefore, the socio-ecological theory appears to give a better explanation of the reasons behind IPV, as it is grounded in the perspective of the diverse and complex interaction of individuals, relationships, community, and societal factors. Further, the socio-ecological theory can integrate both feminist and social science perspectives about IPV (1).

As the context may vary and interpretation of a single factor in their own and exact cycle may challenge the researcher. Therefore, the emphasis should be on the interaction of factors at different levels into the ecological system since it calls for its consideration in the etiology of IPV.

Because the basis of the framework is deriving from empirical data, which may have a limit to state the causality of IPV, it may instead provide correlates. This may then limit the interpretations. Therefore, caution is needed when using the model and considering the causal factors of IPV. Research is still needing to test significant factors to allow causality (41).

How does this thesis circumvent these

We have adopted the socio-ecological framework as a tool for organizing and synthesizing the existing evidence in IPV. This helped to strengthen the convergence of the research findings across different research methods and different settings.

The framework integrates findings of different types of IPV, including physical, sexual and psychological. This had the potential to encourage an integrated approach for theory building to address IPV (1).

Decisions about including each variable and interpreting the results were assisted based on the literature, contextual factors, and the conceptual framework.

The foundation of the socio-ecological theory is based on the interplay of factors within different levels. It may strengthen our understanding of the interrelationships between different levels:

The "Individual-level" examines biological and personal variables, which include the age, economic status of women, the use of alcohol.

The young age of women is a reported predictor for IPV. Suppose a young woman is married to or in a relationship with a partner older than herself. In that case, she may struggle to air her opinions about their relationship. Further, the more senior partner may expose the younger female partner to violence (41).

Further, engaging in sex with older partners reinforces social norms within relationships that could be harmful since they may lead to low support of gender equity, sexual expectations and roles (41).

Economic status has also been shown to be an essential factor associated with IPV. Young women with low financial situations are likely to date employed partners who can fulfil their needs (24). Further, young women under such conditions accept the violence perpetrated by their partners, including having sex when they do not want to and performing other sexual activities. Thus, the young women's reliance on partners exposes them to a higher risk of IPV (5, 21, 24).

The use of alcohol is a cause for concern in that alcohol consumption by both males and females might result in IPV. This could be due to reducing one's inhibitions resulting from alcohol consumption leading to an increased propensity to violence, resulting in physical and sexual abuse (20, 77, 78). It is hypothesized that using alcohol among men may lead them to use negative styles to resolve conflict through their limited ability to use non-violent conflict resolution methods (76). Moreover, men might persuade young women to engage in alcohol drinking to expect that young women will then welcome sex and then use force if they do not agree to engage in sexual activity (20, 24).

In Mozambique, alcohol consumption amongst high school learners has been previously reported as a concern and requires immediate attention (120). It is thus crucial to tackle alcohol use among young people in and out of school to reduce risky behaviors and IPV.

The "Relationship-level" relationship status, partner's employment status, age of partner and HOH education level; Influence of peers; influences of mothers.

The young women's personal experiences at home and friends' experiences shaped their views and expectations about IPV. This may have a role in the attitudes of acceptance of partner violence in

young women (20, 70). Since parents are said to have a role in their children's development, it is thus urgent to design programs that emphasize parental involvement and education about IPV (71).
Working in collaboration with communities is essential so that parents are sensitized more about gender norms. Seminars with mothers and peers to improve their knowledge on GBV, strengthen their skills to prevent IPV, and improve their attitudes on IPV as a role.

The "Community-level" examines the context and the characteristics of the settings. The community level is where an individual is not an active participant but is indirectly affected by activities within the community. We included in the community variables religiosity as a contextual risk factor to investigate how religion might shape social attitudes and young women's perspectives, beliefs, and influences on IPV.
Social scientists recognize that religion is an integrated set of beliefs, behaviors, and norms centered on basic social needs and values rather than individual or personal issues (121).
Religious and faith attitudes in communities form an essential environment where social networks and social norms are formed. As they have the potentiality to protect women against partner violence, these norms may also promote community and social norms that drive violence (122).
Therefore, religious and community culture is an essential context in which the various stakeholders, including community and faith leaders, can address activities to prevent IPV.
Such actions may require a widespread cultural change across families, communities and society (123).
Further, the perpetration of IPV may be encouraged by religious institutions as promoting norms that require females to be submissive to their partners. Such churches may endorse the religious beliefs of male superiority and use them against married women.
A qualitative study among Togolese women reported a high tolerance of IPV among those committed to religion (124). This could be because women are supposed to always show respect and be obedient towards their partners in some religions. IPV may be acceptable according to such religious beliefs (125).
Another evidence was the finding from a study exploring the links between religious affiliation and IPV among women in Ghana (126). The women who were committed to religion were less likely to disclose IPV openly.
There are many different churches in the Mozambican context, and people can freely choose to attend whichever they prefer. At the same time, they may be tolerant of violent behavior if their religion enforces gender inequalities and ideas about male dominance and female submissiveness.

The issue of religious beliefs and their relationship with IPV appears to be complex and calls for further research on how religious values might shape social attitudes and perspectives on IPV.
Religiosity is worth addressing through collaborations with community members and the educational sector to promote awareness about IPV and recognize and prevent it amongst young women in Maputo. This, therefore, suggest that the various religions could have a role in preventing IPV through their social and cultural perspectives.

The "Societal-level" examines the social context, the cultural norms such as the gender norms regarding male dominance and the acceptance of violence.
The construction of masculinity has been recognized as a negative influence on IPV. The cultural construction of masculinity is perceived as masculine superiority, contributing to gender inequalities, conflicts, and partner violence within families and communities (21, 23).
Gender norms that give privilege to men's dominance over women, and the acceptance of wife-beating and men's entitlement to sex, have been identified as major socio-cultural factors underlying IPV (19, 23, 41)
In Mozambique, therefore, current gender norms privilege male dominance over women. Two studies revealed that it is perceived as normal and acceptable for men in some cultures to have more than one partner (7, 8, 24).
The findings from another study revealed that young women justified a man's right to have sex and that women should satisfy men at any time (10). The existing socio-cultural vulnerabilities among young women may result from the social context or environment where they are integrated, such as the community where they live, which may endorse strong ideologies of male dominance.
Comprehensive programs need to empower younger women with skills to challenge such harmful gender norms when implementing IPV and collaborate with the community and the educational sector to change gender norms regarding male dominance.

The adapted theoretical framework guiding this study is presented as Figure 1 below:

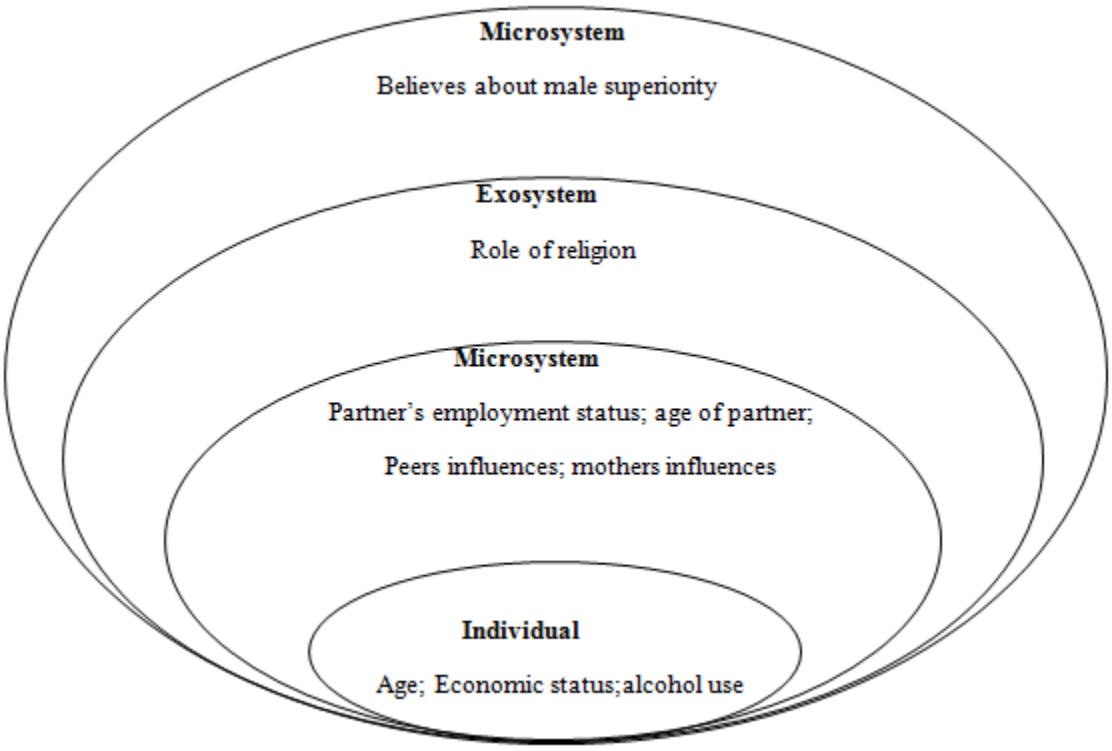

Figure 1. Theoretical framework: Adapted from the socio-ecological model (1)

3.3 Study area and Setting

The study was implemented in the KaMfhumu district, area of Maputo city. The KaMphumu district is located in Maputo city, one of the eleven administrative regions of Mozambique. It is the most urban area with 12 square kilometres and a total population of 80 550, where 37 975 are males and 42 575 are females. It has the lowest poverty level among the seven districts, estimated at 28% (127).

Youth in the age group of 14−24 constitute about 49% of the population in this area (127). Maputo's metropolitan area is the leading financial, corporate, and commercial center of the country, populated by people from different backgrounds, economic classes, cultures, and diverse perspectives concerning their health-seeking behavior. It also offers the highest educational accessibility where the schools enrol many learners from various peri-urban areas (127).

There are seven secondary schools (level 2) in the area, but only three of these hold classes both in the day and evening for grades 8 to 12. Other secondary schools are at level 1 and have grades 8 to 10 for learners in the age range of 13−15 years (127).

We selected secondary schools of level 2 to find learners aged 15−24 years who were the target group. Since Mozambique is a developing country, children often enter school when they are older than in other countries. They continue to attend school above the age of 20 (127).

Further, secondary schools are often the setting where young women receive education and health promotion programs. Therefore, it is feasible that comprehensive programs can be provided to empower young women with the knowledge and skills to reduce their vulnerabilities. Such interventions can change behaviors through collaboration with the educational sector and consideration of the contextual environment when targeting youth. (Figure 2. Map of Maputo city/KaMpfumu district).

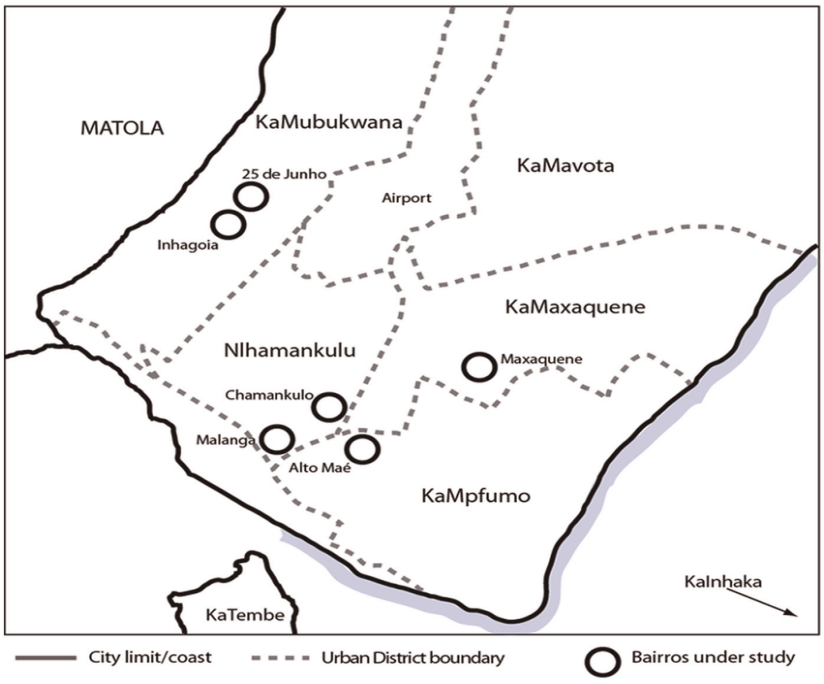

Figure 2. Map of Maputo city/KaMpfumu district

Source: https://www.researchgate.net/figure/The-city-of-Maputo_fig1_274536689

3.4 Study design

The study used mixed methods, employing an exploratory sequential design using qualitative and quantitative methods (114). It was underpinned by the Social-Ecological Theory (1).

3.5 Study population

The study population comprised female students aged between 15−24 years in Maputo schools.

3.6 Study sample

The study sample comprised female students 15−24 years attending three selected schools. The schools were selected as they had grades 8-12, and women aged 15−24 years were selected as they are at increased risk of adverse health and reproductive health outcomes (34, 81).

3.7 Sample size

3.7.1 Qualitative study-exploratory design

The sample size estimation was based on data saturation criteria. Data were collected until the respondents provided no new information. It involved a total of 66 participants participating in six Focus Group Discussions (FGDs).

3.7.2 Quantitative study –a cross-sectional design

The sample size calculation was based on a population-proportional size sample, using a 95% confidence interval and a 5% degree of precision. We expected a 50% prevalence of IPV, and in addition, we added 10% to the sample size for nonresponse. The final size sample was 424 (128).

Sample size estimation formula (Lameshow, 1990):

$n=Z^2pq/E^2$ Where:

n= sample size; z= confidence level (95%) =1.96; p= prevalence=0.5; q=sampling distribution=1-p; E= margin of error= 0.05

Calculation:

$n= (1.96)^2(0.5)\ (0.5)/0.0025$

n=385+ 10%

n=385+ 39

n=424

3.8 Selection of the participants and enrolment

3.8.1 Selection for FGDs

We used non-probability purposive sampling to recruit participants. The potential participants (Women between the ages of 15 and 24 years registered and attending one of the selected schools) were invited to a meeting that explained IPV, the study objectives and methods.

Participants were purposively selected based on their ages and availability. Thus, participants between the ages of 15−24 who were selected and who volunteered and were available to participate at the time were invited for the FGD.

3.8.2 Selection for survey

Meetings were held in each school. Each academic class was visited to identify eligible participants to explain IPV and the study objectives and methods.

We used the probability proportional random sampling strategy. A list with eligible potential participants was employed to select the participants per academic class, based on the total number of students per academic class and age group.

We had previously sampled the participants in each school using proportional sampling, based in the total number of young women enrolled in the age range of 15-24 years, in each school using the formula: sample size/population size) x stratum size (128).

We then had a list of potential participants per academic class. We then assigned numbers to the units we applied for the random numbers and selected the sample. Using the proportional random selection technique provided an equal chance for all the students to be selected to generalise the findings to similar populations.

The random selection provided an equal chance for all the students to be amongst those selected to generalise the findings to similar populations. All the participants who mentioned that they had never been in a relationship (n=19) were subsequently excluded from the study.

3.9 Inclusion criteria for participants

Women between the ages of 15 and 24 years registered and attending one of the selected schools.

Willing to participate in the study.

Willing and able to provide informed consent (for those above the age of 18) or assent and written parental consent (for those under the age of 18).

Ever been in a relationship since the age of 15.

3. 10 Data collection

3. 10.1 Qualitative data collection- FGD

We selected Focus Group Discussions (FGDs) as the method of gathering data. FGDs are a valuable method to explore the participants' perspectives, attitudes and experiences while allowing the researcher to observe the dynamics within the group (129).

Before the discussion, potential participants were invited to a meeting that explained IPV and the study objectives and methods. Participants who volunteered to participate were scheduled for the FGDs. In total, 66 students, who constituted six FGDs, voluntarily attended. Only students attending day classes were willing to participate.

Before the discussion, the researcher emphasized confidentiality and anonymity of the information shared within a group. It was also explained to the participants that the transcripts and audio recordings would be kept anonymized by removing each person's name or any other identifying data and would be kept strictly confidential. However, participants were cautioned about the lack of privacy and the limited confidentiality in sharing personal experiences within a group. To minimize this, the researcher advised the participants to rather discuss what they have learned and observed in their communities.

We then conducted FGDs in the three selected secondary schools and to ensure geographical representation, we held two FGDs in each school. Each FGD comprised 10-12 participants. However, after the sixth FGD, the team stopped as they were no longer obtaining new information.

The FGDs were conducted over six weeks between August and September 2019. The duration of each discussion was between 1.0 and 1.5 hours. The meetings took place at the respective schools in a quiet room, agreed as suitable by all the participants. The discussions were conducted in Portuguese, the official language of Mozambique, and the language most used in urban settings.

To facilitate the discussions, we used an FGD guide comprising the following topics: What do young women perceive to be the factors influencing IPV? If young women ever saw or know someone who has ever experienced violence by a partner? The meanings and views regarding IPV and the attitudes of young women concerning IPV were also discussed.

All FGDs were conducted by the first author. At the same time, a research assistant was employed to assist with managing the audio recording and note-taking. The note-taking also helped with observing

and capturing the non-verbal information. The research team held a short meeting at the end of each discussion to validate the collected data.

3.10.2 Quantitative data collection- Survey

A survey was conducted among the 450 women aged 15−24 attending the three selected schools from the 23rd of August to the 22nd of October 2019. The data were collected using a self-administered questionnaire. The collection was conducted by the principal researcher and two Research Assistants (RAs). The RAs were trained to aid in the data collection. A week before, they received their training to familiarize themselves with the aim, research methods, instruments, and ethical issues. Participants in the FGD did not complete the survey.

The questionnaire used was adapted from the WHO Multi-country Survey of Women's Health and Domestic Violence against Women (47). The questionnaire was translated from English to Portuguese and back-translated into English by a second translator to ensure consistency and local usage. The selection of the questions was designed to address the socio-cultural context of the young women attending secondary schools in Maputo.

Dependent variables

The dependent variables comprised acts of physical, sexual and psychological violence, using the subscales of the Abusive Behavior Inventory of physical violence (51), psychological violence (130) and sexual violence (131).

Physical, sexual or psychological violence was assessed by questioning if, since the age of 15, the young women had ever experienced one of these acts from a current or past partner. Experience of physical, sexual or psychological violence was considered confirmed if the response was "yes" to at least one of the defined criteria questions.

The lifetime prevalence of IPV was calculated as the proportion of women who have or ever had an intimate partner and reported violence from a partner at any time in their lives since 15 years (51).

The current prevalence or 12 months prevalence of IPV was calculated as the proportion of women who currently have or ever had an intimate partner in the previous 12 months before the survey and reported violence by an intimate partner in the previous 12 months (51).

An intimate partner was defined as any male partner with whom the young women have or ever had a romantic relationship that included sexual activities, either spouse/husband, boyfriend/dating partner, or ongoing sexual partner/occasional partner (51).

Independent variables

Prior to the survey, an exploratory study using focus group discussions was conducted and themes were generated to explain the IPV experienced by young women in Maputo city. For example, the focus group discussing study linked religiosity with risk behaviours and IPV. Therefore, we included religiosity as a contextual risk factor to investigate how religion might shape young women's perspectives, believes and influences on IPV.

Perpetration of IPV may be encouraged by religious institutions as promoting norms that require females to be submissive to their partners and that such churches may endorse the religious beliefs of male superiority and use them against married women (121).

Social scientists recognize that religion is an integrated set of beliefs, behaviors, and norms centered on basic social needs and values rather than individual or personal issues (121). The community level in the ecological system is where an individual is not an active participant but is indirectly affected by activities within the community (1).

Religious believes and attitudes occurring in communities form an important environment where social networks and social norms are formed. These norms have the potentiality to protect women against partner violence. They may also promote community and social norms that drive violence (122). Therefore, religious and community culture is an essential context in which the various stakeholders, including community and faith leaders, can address activities to prevent IPV. Such actions may require a widespread cultural change across families, communities and society (123).

The issue of religious beliefs and their relationship with IPV appears to be complex and calls for further research on how religious values might shape social attitudes and perspectives on IPV.

Religiosity is worth addressing through collaborations with community members and the educational sector to promote awareness about IPV and recognize and prevent it amongst young women in Maputo. This, therefore, suggest that the various religions could have a role in preventing IPV through their social and cultural perspectives. We included in the community variables religiosity as a contextual risk factor to investigate how religion might shape social attitudes and young women's perspectives, beliefs, and influences on IPV.

Therefore, based on the WHO Multi-country surveys of violence against women, the questionnaire was informed by the contextual themes and the available literature to explain the risk factors for IPV in different socio-cultural contexts (2, 115). Thus, the combination of approaches resulted in the set of variables that were investigated.

The following themes (Table 1) informed the selection of the variables:

Table 2. Themes and variables

Themes	**variables**
knowledge of young women about IPV (witnessing friends being physically abused by their partners, from friends sharing personal experiences of IPV and experiencing the accepting attitudes of their mothers toward IPV)	Influences of peers; Influences of mothers
Points of view of young women on IPV as a violation of the human rights	Agreement with the statement of male superiority; partner alcohol
Reasons for acceptance of abuse are the (Individual) low economic status of women, alcohol use the (community), their religious beliefs and the (societal) acceptance of violence and the male chauvinism	Socioeconomic status; Commitment with religion; use of alcohol; Statement of acceptance of violence; Agreement with the statement about male superiority

We also based our questions on the Socio-ecological Model, which established that the risk factors for IPV emerge from different constructions within people's interactions, including individual, community and societal factors (1, 119).

The available literature also informed the variables to explain the risk factors for IPV in different socio-cultural contexts.

In settings such as Mozambique, the society is dictated by social norms which give privilege to male dominance (6, 8, 10, 24). Thus, contextual socio-cultural factors may explain the occurrence of IPV. Therefore we included socio-cultural variables.

There was a limitation that the study did not ask about childhood experiences of violence or previous exposure in their households and friends to have to witness violence.

Piloting the questionnaire

The questionnaire was piloted in a school with a similar setting but not included in the study, amongst 42 young women (nearly 10%), to ensure clarity of the questions and consistency in the questioning methods and the data collection procedure.

Content validity was also ensured by asking similar questions in different ways at different places in the questionnaire. After the pilot, some issues relating to the demographic information, such as the area of residence, the locality of birth and where they grew up, were re-formulated based on the socio-cultural context of an urban setting in Maputo and addressed the specific group of school-going population.

3.11 Data entry and analysis

3.11.1 Qualitative data entry and analysis

The FGDs were tape-recorded, listened to and transcribed verbatim. The transcribed data were translated from Portuguese to English and back-translated into Portuguese for validation. Data were then entered into NVivo V10. The software is used to manage the textual data and maintain an audit trail (132).

Data were coded and were then analyzed through thematic analysis, in line with the ecological framework. Thematic analysis was suitable for this analysis as it allowed the researcher to identify the emerging themes from the data set, and these were used to further probe the views of young women in subsequent FGDs. An inductive approach was applied to ensure that the themes were developed from the data set but that, at the same time, the research questions drove the coding process.

Braun and Clarke (2006) suggest a thematic analysis. This iterative and reflective process develops over time and involves constantly moving back and forward between 6 phases. The method aims to identify, analyse and report repeated patterns of meaning or themes within a data set.

The guidelines outlined by Braun and Clarke (2006) were the basis for performing the thematic analyses as a flexible technique that enabled the researcher to determine themes in several ways. Braun and Clarke recommend the steps below:

I) familiarizing with the data; ii) generating initial codes; iii) searching for themes; iv) reviewing themes; v) defining and naming themes, and vi) producing the report.

In doing so, the researcher firstly familiarized herself with data, which means a Prolong engagement with data through reading rapidity, document thoughts about potential codes, and consider the frequency and relevance for the research question. At that point, codes were developed.

Codes were highlighted using different colours for the various codes in the transcripts. The team compared and discussed their codes and then reread them, using the data extracts until consensus was reached. This procedure ensured inter-rater consistency.

All identified codes with similar meanings were then grouped to form themes. Subsequently, the themes were reviewed and compared again with the transcripts to find relevant data associated with the themes and to map and interpret the whole data set in a thematic map (133). Tables were drawn to organize the grouped codes and several themes.

As the method for identifying, analyzing, organizing, describing, and reporting themes found within a data set (Braun & Clarke, 2006), thematic analysis was found suitable for identifying and describing young women views and perspectives, highlighting similarities and differences, and also generating unanticipated insights (133, 135).

It has the relevance of analyzing large qualitative data in a timely and rigorous manner using a structured approach to handle this, which helped to ensure trustworthy data (134, 135).

While thematic analysis has the advantage of flexibility, this flexibility can also become a disadvantage leading to inconsistency and a lack of coherence when developing themes derived from the research data (136).

3.11.2 Quantitative data entry and analysis

Overall, 450 young women were enrolled in the study, but only 431 were included in the analysis. The remained 19 mentioned that they had never been in a relationship and were subsequently excluded for analysis.

Data were entered into SPSS version 25.0 computer software and cleaned. After assessing its completeness, data were analyzed. Descriptive statistics provided a summary of the sample and the variables measured.

The categorical variables were summarized using frequency distributions. Proportions were used to estimate the lifetime and current or 12 months prevalence of IPV among young women (51).

Logistic regression was used to identify risk factors associated with IPV, and odds ratios (OR) and 95% confidence intervals (CI) are reported.

The Hosmer and Lemeshow test of the goodness of fit suggested the model was a good fit to the data as p=0.396 (> 0.05). The chi-square statistic on which it is based is very dependent on sample size, so the value cannot be interpreted in isolation from the sample size. However, the study had a powered sample size. The data also met the one in ten rule of thumb of ten outcome events per predictor variable in the logistic regression.

After conducting the bivariate analysis of IPV and the potential risk factors, statistically significant risk factors were then included in the multivariable logistic regression. The relationship was deemed statistically significant, as illustrated by the p-value, $P < 0.05$.

3.12 Qualitative data: Trustworthiness of the qualitative data, Credibility and Transferability

The researcher applied mixed methods, ensuring that multiple perspectives are reflected in the findings. This minimized the threats to the trustworthiness of the qualitative data and improved its credibility. To enhance the trustworthiness of the data, the researcher performed a verbatim transcription of all FGDs.

The researcher verified the interpretations to ensure that the data accurately represent the information that the participant provided. This action improved the credibility and was operationalized through member checking to test the researcher interpretations (134).

The researcher also performed an audit trail assessing the whole research process to ensure that records were kept, whether the reasons behind the emergent themes were meaningful and that the conclusions were grounded in the data. Finally, the study supervisor re-analysed and validated the identified themes as another researcher (115).

The study focused on young women attending classes in secondary schools in Maputo. The findings may be transferable to other young women attending secondary schools in a similar setting elsewhere.

3.13 Quantitative data: Validity, Reliability and Generalizability

This study used pretested and validated instruments from the WHO Multi-country Survey of Women's Health and Domestic Violence against Women (47, 137).

The questionnaire's validity in the Portuguese language was confirmed in the study done in Brazil in two different social contexts (urban and rural). The results indicated the adequacy of the instrument in estimating the occurrence of IPV and the associated factors. The tool has been shown to be reliable, consistent, and adequate for use in similar studies accessing IPV in different contexts, such as this study (137). (See Appendix 1I)

Generalizability

External validity refers to the extent to which the quantitative results of the study can be generalized to and across populations. The size of the sample was adequate to ensure a 95% confidence interval.

3.14 Bias

3.14.1 Selection Bias

The study may have selection bias as it was conducted amongst young women attending the three leading schools of the KaMfhumu district, area of Maputo city. The schools are the major schools in Maputo city and enrol students from grade 8 to 12 in day and evening classes. The schools were selected on the basis of literacy so that the questionnaire could be completed anonymously.

3.14.2 Information Bias

Although the questionnaire was self-administered, the RA was trained to be consistent in reading the definition of the terms to all participants prior to their completing the questionnaire throughout the process.

3.14.3 Social Desirability Bias

The study may have a social desirability bias as the participants might have furnished information that would impress the researcher and not the reality that prevails in real situations. Examples thereof involved responses concerning sexual activities, their partner's age and alcohol use, religiosity, having experienced any act of physical, sexual or psychological violence. To reduce the bias,

participants were assured anonymity and advised that their responses were most helpful if they reflected the true situation.

3.15 Ethical considerations

3. 15.1 Ethical Approval

This study was approved by the Humanities and Social Sciences Research Ethics Committee of UKZN (HSSREC) ref: HSS/2005/018D and the National Health Bioethics Committee of Mozambique (CNBS) ref: 360/CNBS/19. (See Appendix A & B).

3.15.2 Permission

Permission was obtained from the National Directorate of Education in Maputo and the Directorates of the schools. Consent forms and assent forms (for those younger than 18) were explained and distributed to all participants before the study. All participants provided written informed consent voluntarily.

Participants under 18 years of age provided assent and written consent from their parents/guardians. After returning the signed consent forms, participants were eligible to participate in the study.

No monetary reimbursement was given to participants for their participation. However, they were offered a light lunch during the FGDs.

Participants were advised that the aim of the discussion was not to share their personal experiences, rather their perspectives concerning IPV and the experiences from their communities.

Anonymity and confidentiality were ensured, and participants' names were not written on any results. Privacy was maintained by keeping the participants separated from each other during the completion of the self-administered questionnaire.

Participants were told that their participation was voluntary and that they have the right to terminate their participation. They were assured that they would not be affected if they decide to terminate their participation.

There was a risk that the study had the potential to bring back negative memories. Thus, participants were told to inform the researchers if this occurred, and they were assured of the availability of referral services.

Participants benefited from the information about IPV and how to prevent IPV, which was provided after the study. The researcher made available contacts for reference services for assistance in case participants needed help if they experience violence.

Those participants who contacted the researcher after the study who reported experiencing IPV were provided with the names and contact details of the services assisting women suffering from gender-based violence and IPV.

3.16 Data management and storage

FGDs participants' names were not transcribed, although codes were generated with pseudonyms. All records were kept confidential and identified with the unique subject 's identification number. The survey questionnaires were sealed in envelopes and stored in locked cabinets of the researcher to ensure safety and security. No names were marked on questionnaires to ensure anonymity and confidentiality. Instead, we used codes to identify participants' responses.

All data collected (qualitative and quantitative) were categorized into soft and hard copy. The soft copies, including the backup files and databases, were coded. A password was put on this, only accessible to supervisors and the principal researcher.

The hard copies were adequately packaged and stored with the principal researcher, securely locked in a cabinet. After five years from the date all findings are published, they will be shredded and sent to the final disposal site to destroy official documents, as recommended by the UKZN and the Mozambican ethics committees (UKZN-HSSREC and CNBS-Mozambique).

3.17 Organization of the research

The principal researcher (the PhD student) had the role of the overall management of the implementation of all stages of the study. This included the engagement of the stakeholders to facilitate buy-in and the recruitment of the participants.

The student also negotiated entry with gatekeepers such as the Maputo Directorate of Education and the KaMphumu high school managers. Assistance from the counselling teachers for venues and other logistics were required in the schools.

The student was also responsible for ensuring compliance with bioethics regulations at all stages of the study. She conceptualized and developed the proposal for the project. The student required guidance from the UKZN statistician and her supervisors on sampling, data analysis and interpretation.

The student was also responsible for ensuring the scientific rigour of the study's implementation, ensuring accurate data analysis, interpretation and writing- up of the papers and the thesis.

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CHAPTER FOUR

PUBLICATION

Paper 1: Mapping evidence of socio-cultural factors in intimate partner violence among young women: a scoping review protocol.

Authors: Maguele, MSB and Khuzwayo, N

Status: Published

Date published: December 6, 2019

Journal: BMC, Systematic reviews; Maguele and Khuzwayo Systematic Reviews (2019) 8:312https://doi.org/10.1186/s13643-019-1234-y

Introduction

Sub-Saharan Africa carries the highest burden of intimate partner violence among young women. Thus, the understanding of socio-cultural factors influencing IPV among young women in SSA is critical in order to develop effective interventions to reduce the burden. To determine what is known about this problem, we conducted a scoping review to determine the extent to which studies on socio-cultural factors influencing IPV among young women have been conducted. To do this, it was necessary, a priori, to develop a protocol for such a review, to enable us to describe the rationale and hypothesis and to plan the methodology for the review of socio-cultural factors influencing IPV among young women in SSA.

The paper published in "Systematic Reviews" is presented below

Doctoral student's contribution

I conceptualised the study under the guidance of the Supervisor, Dr Nelisiwe Khuzwayo. I carried out the literature search and drafted the manuscript. I prepared the manuscript, and the Supervisor reviewed this. After that, my Supervisor and I checked the final version. This was submitted and published in 2019.

Maguele and Khuzwayo *Systematic Reviews* (2019) 8:312
https://doi.org/10.1186/s13643-019-1234-y

Systematic Reviews

PROTOCOL Open Access

Mapping evidence of socio-cultural factors in intimate partner violence among young women: a scoping review protocol

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Abstract

Background: Intimate partner violence among young women continues to be a worldwide concern. Globally, a considerable number of studies reported numerous factors that influence intimate partner violence among the young. The proposed scoping review aims to map available evidence of socio-cultural factors influencing intimate partner violence among young women.

Methods: We will conduct a scoping review to explore, describe and map literature on socio-cultural factors influencing intimate partner violence among young women. The search strategy for this scoping review study will involve electronic databases including PubMed, Web of Knowledge, Science Direct, EBSCOHost (PubMed, CINAHL with Full Text, MEDLINE), Google Scholar, BioMed Central and World Health Organization library. Articles will also be searched through the "Cited by" search as well as citations included in the reference lists of included articles. Keyword searches will be used, and two independent reviewers will be screening titles, abstracts and full articles; where there are disputes between the two reviewers, a third reviewer will intervene. Thematic analysis will be employed to present the narrative account of the review.

Discussion: Understanding socio-cultural factors influencing intimate partner violence among young women is critical. This will enable researchers to map existing literature, map research gaps and guide future research.

Systematic review registration: PROSPERO (CRD42018116463)

Keywords: Intimate partner violence, Violence against women, Socio-cultural factors, Dating violence, Domestic violence

Background

Intimate partner violence (IPV) as defined by the World Health Organization (WHO) is a global phenomenon of violent acts that include physical, sexual and psychological/emotional abuse by a current or former intimate partner [1]. The WHO estimates that one in three (>30%) women experience violence from their partners globally, and the region of Sub-Saharan Africa (SSA) has shown higher prevalence where the statistics point to 36.6% [2, 3].

IPV among young women have been the subject of intense debate within the scientific community. Worldwide, IPV among ever-partnered young women aged 20–24 years was estimated to be around 31.6% and 29.4% among women aged 15–24 years in 2013 [4]. Of concern is the early exposure of young women to IPV since they are in the transitional stages of development [3, 5].

There are numerous factors influencing IPV among young women including HIV-positive status, level of education, economic status [6], alcohol abuse and socio-cultural factors [7]. There is a consensus among social scientists that young women who are subjected to IPV are more likely to acquire negative health outcomes including unwanted pregnancy, abortion, sexually transmitted infections including HIV, injuries or being murdered [8]. While factors influencing IPV among women are well documented, it is particularly important to understand socio-cultural factors influencing IPV

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2180
2181

among young women. Knowing that this is potencially the group of population with other risk factors including the risk of IPV, therefore the impact of IPV could be relatevely higher [5, 9]. Socio-cultural factors are beliefs, customs and practices within cultures and societies that affect the thoughts, feelings and behaviours of the community members [10]. Although socio-cultural factors influencing IPV are evident among older women, there are fewer studies focusing on younger women [7].

This information will be vital for researchers, governments and non-governmental organizations for the development of context-based primary interventions and policies. Further, the information generated from this review will benefit health authorities, health care workers, academics and general public. It will also be useful for educational purposes.

Therefore, this scoping review seeks to:

❖ Map existing types of socio-cultural factors influencing IPV among young women in Sub-Saharan Africa

❖ Map the extent in which socio-cultural factors promote IPV victimization of young women

❖ Determine the nature and quality of studies reporting evidence of socio-cultural factors on the intimate partner violence among young women

The findings from this review will enable the researchers to examine the extent, range and nature of research activity on IPV and socio-cultural factors among young women in Sub-Saharan Africa. The findings will also enable the researchers to identify and describe the context in which young women experience IPV as well as the main reasons for it.

Methodology

The current scoping review protocol is registered and published in PROSPERO, an international prospective register for systematic reviews under the following registration number: CRD42018116463.

The framework adopted for conducting the proposed review is by Arksey and O'Malley [11]. Briefly, the framework involves (i) identifying the research question, (ii) identifying relevant studies, (iii) study selection, (iv) charting the data and (v) collating, summarizing and reporting the results. This scoping review will include quality appraisal of studies.

Identifying the research question

What is the available evidence of socio-cultural factors in IPV among young women? The research sub-questions are:

1. Is there evidence of types of socio-cultural practices on IPV among young women in Sub-Saharan Africa?
2. Is there evidence that shows that socio-cultural factors contribute to IPV victimization among young women in Sub-Saharan Africa?
3. Is there evidence of the nature and quality of the studies reporting evidence of socio-cultural factors on IPV among young women in Sub-Saharan Africa?

Eligibility Criteria

The study will use an amended PICOS (Population, Intervention, Comparison, Outcomes and Study setting) framework to determine the eligibility of the research questions (Table 1).

Inclusion criteria

We will include

- Studies that show evidence on socio-cultural factors on IPV
- Studies that show evidence of intervention on IPV
- Studies that include the following outcomes: IPV, socio-cultural factors, morbidity/mortality and health effects of IPV
- Studies done in SSA

Exclusion criteria

We will exclude

- Studies reporting evidence of IPV among women under the age of 15 and women above the age of 24
- Studies that were published before 2008
- Studies on non-partner intimate violence
- Studies evidencing intervention on non-male intimate partner violence against women

Identifying relevant studies

Primary research articles published in peer-reviewed journals, review articles and grey literature that addresses the main research question will be included in this study. All study designs will be included in this review. Databases that the study will use to source literature include PubMed, CINAHL with Full Text, Health Sources MEDLINE, World Health Organization (WHO) and governmental websites which would be searched for policies and reports. This study will also use reference lists and existing networks such as organizations and conferences to source

Table 1 PICOS framework

Criteria	Determinants
Population	Young women aged 15–24 experiencing IPV
Intervention	Socio-cultural factors, intimate partner violence
Comparison	N/A
Outcomes	Intimate partner violence, socio-cultural factors
Study setting	Sub-Saharan Africa

Table 2 Database search record

Date of search - Search engine - Keyword search - Number of articles found - Number of articles eligible

relevant literature. The search terms will include "Intimate partner violence", "Factors influencing intimate partner violence", "socio-cultural factors on the intimate partner violence", "dating violence", and "domestic violence".

This review will search studies that were published in any language; by not restricting languages of publications, all languages will thus be included.

The search strategy will be first piloted to determine the validity and reliability of the criteria of the study selection (Table 2). The pilot search results are presented in Appendix 1 (Table 4). The engine used is the MEDLINE database via EBSCOHost using the MeSH terms for searching.

Study selection

The study will conduct a comprehensive title screening by searching and uploading all literature search results on Endnote X7 software (Fig. 1). All the studies that do not address the research questions will be excluded together with all the duplicates. The reviewers will seek assistance from the UKZN library services for articles that are difficult to find. The reviewers will also contact authors to request full copies of the included articles that are not available via the databases and UKZN library. The final Endnote database will be shared among the review team for abstract screening; at this stage, two independent reviewers will screen the abstracts and full articles, with guidance from the inclusion criteria. Copies of full articles for eligible studies will be obtained and maintained for data extraction.

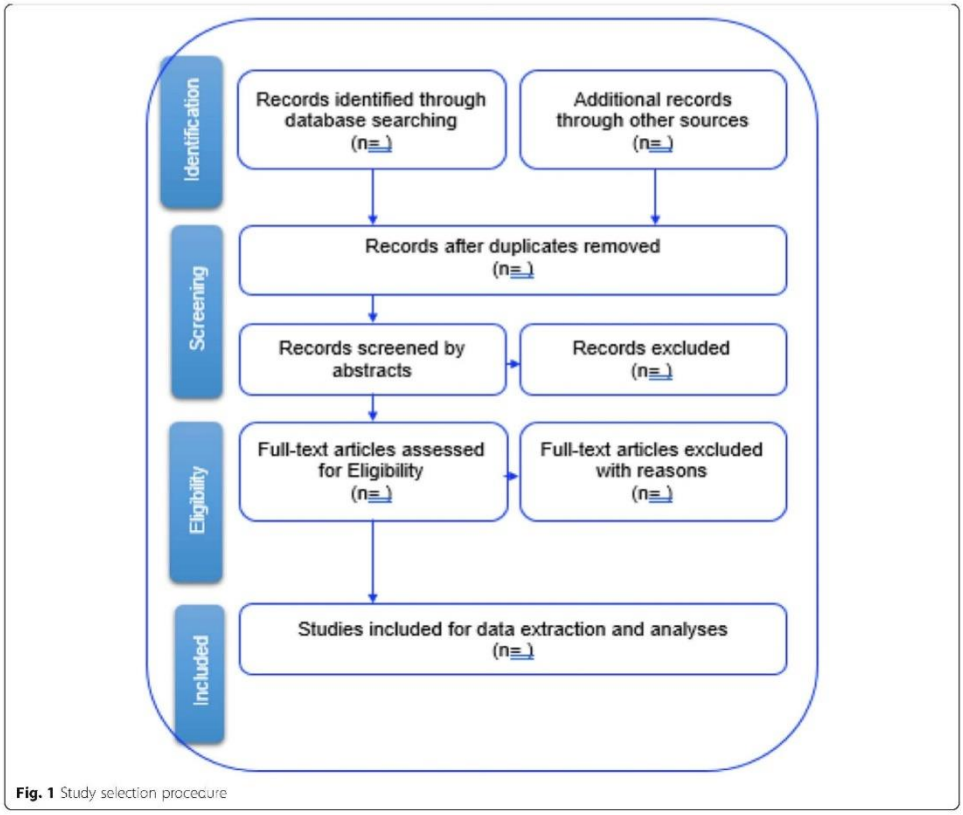

Fig. 1 Study selection procedure

Table 3 Data charting form

Author and date
Study design
Study setting
Population
Overage age
Sample size
Aims
Interventions
Outcomes
Key findings
Conclusion
Comments

Charting the data

The researchers will use a standardized data extraction sheet (Appendix 2, Table 5). The sheet will include bibliographic details, study design, number of participants, intervention, study setting, significant findings and conclusions for the primary and the secondary outcomes of the intervention (Table 3).

Collating, summarizing and reporting the results

The researchers will present a narrative account of the findings from the existing literature through a thematic content analysis of the extracted literature. The themes will be structured around the following interned outcomes which will be coded by all authors independently: socio-cultural, economic and behavioural factors, and experiences and reasons for acceptance of IPV. The emerging theme will also be reported. In aiding the thematic analysis, NVivo version 10 shall be used. The subsequent processes will be followed:

Coding
Categorize codes into major themes
Build theme-related themes (cut-and-paste technique)
Display data
Identify patterns in the data and identify sub-themes
Summarize

Quality assessment

Authors will interrogate the resulting themes and critically examine their relationship to the research questions. Authors will also scrutinize the meanings of the findings as they relate to the overall aim of the study and the implications for future research. A quality appraisal tool which focuses on the study methods, the Mixed Method Quality Appraisal Tool (MMAT), version 2011, will be used [12]. The tool will be used to examine the quality of an article looking at the following aspects: the appropriateness of the aim of the study, adequacy and methodology, study design, participant recruitment, data collection, data analysis, presentation of findings, authors' discussions and conclusions.

Discussion

The scoping review will be conducted as a first part of the study focusing on socio-cultural factors influencing IPVAYW in Mozambique. This scoping review aims to map evidence of socio-cultural factors in IPV among young women in SSA. The findings of this review will identify the extent to which socio-cultural factors among young women influence IPV. The purpose is to establish the extent of existing research on socio-cultural factors on IPV in SSA. Although studies on factors of IPV are taking place in these countries [7], there is still a scarcity of evidence on types of socio-cultural factors on the IPVAYW [1, 10]. The researchers will limit the research to include published studies from 2008 to 2019. A 10-year literature search is more likely to yield a comprehensive and balanced account of previous and current research in the area and to capture past as well as emerging perspectives on interventions on socio-cultural factors on IPV. This review will exclude studies that report evidence on non-partner intimate violence, as the focus is on intimate partner violence. The researchers therefore anticipate finding relevant literature on IPV in SSA. The results will provide documented evidence on socio-cultural factors on the IPVAYW and will help identify requirement priorities for primary research in this area. Due to how this study proposes to guide future research, the dissemination plans include presentations on public health institutions, local stakeholders, conference presentations and publication in journals. The review will also identify priorities for primary research and future research.

Appendix 1

Table 4 Results of the pilot search

Date of search	Search engine used	Keyword searched	Number of publications retrieved
8 May 2019	MEDLINE via EBSCOHost	("intimate partner violence") AND ("sociocultural factors") AND ("dating violence") AND ("violence against Human") AND ("domestic violence") AND ("Young women") AND ("Sub Saharan Africa") Published date: 2008 Jan 1 to 2019 Dec 31 Source types: academic journals	7570

Appendix 2

Table 5 Sample data extraction form

Study details
Author/year
Objectives
Participants (characteristics/total number)
Setting/context
Interventions
Search details
Sources searched
Years of included studies
Number of studies included/types or studies included
Country of origin of included studies
Appraisal
Appraisal instruments used
Appraisal rating
Analysis
Method of analysis
Outcome assessed
Result findings
Significance/direction

Abbreviations
IPVAYW: Intimate partner violence among young women; SSA: Sub-Saharan Africa; WHO: World Health Organization; YW: Young woman

Acknowledgements
The Instituto Superior de Ciências de Saúde - ISCISA (Maputo, Mozambique), The Netherlands Initiative for Capacity development in Higher Education (NICHE) and the University of KwaZulu-Natal (Durban South Africa) are acknowledged for the provision of resources towards this review.

Authors' contributions
MSB conceptualized and designed the data collection methods and prepared the draft proposal of the study under the supervision of NK. MSB contributed to the writing of the first draft of the manuscript. MSB prepared the manuscript and NK reviewed it. All authors contributed to the reviewed draft version of the manuscript and approved the final version.

Funding
Not applicable

Availability of data and materials
All data generated or analysed during this study will be included in the published systematic review article.

Ethics approval and consent to participate
Not applicable

Consent for publication
Not applicable

Competing interests
The authors declare that they have no competing interests.

Received: 27 January 2019 Accepted: 13 November 2019

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Publisher's Note

2188

CHAPTER FIVE

PUBLICATION

Paper 2: Evidence of socio-cultural factors influencing intimate partner violence among young women in Sub-Saharan Africa: A scoping review

Authors*:* Maria Suzana Maguele, Myra Taylor, Nelisiwe Khuzwayo.

Status: Published

Date published: December 8, 2020

Journal: BMJ Open; Maguele MS, Taylor M, Khuzwayo N. Evidence of sociocultural factors influencing intimate partner violence among young women in sub-Saharan Africa: a scoping review. BMJ Open 2020;10: e040641. doi:10.1136/BMJ open-2020-040641

Introduction

Followed the structured method described in the review protocol (Paper 1) in Chapter 4, we conducted the scoping review to scope and document evidence of socio-cultural factors influencing intimate partner violence among young women in SSA.

Doctoral student's contribution

I, Maria Suzana Maguele conceptualised and prepared the draft proposal of the study under the supervision of Professor Myra Taylor and Dr Nelisiwe Khuzwayo. I did the literature search, data analysis and drafted the manuscript. Portia Nelisiwe contributed to the abstract and full-article screening. Neusa Torres Tovela contributed to resolving the discrepancies between two reviewers during the full-article screening. Dr Tivani Mashamba-Thompson assisted with the scoping review methodology, degree of understanding of screeners and the risk of bias assessment. Desmond Kuupiel assisted with a quality appraisal. My supervisors critically reviewed the manuscript; all authors reviewed and approved the final version.

Although the abstract concludes on the ecological framework, which the results section did not present, the different factors were summarized.

BMJ Open

Evidence of sociocultural factors influencing intimate partner violence among young women in sub-Saharan Africa: a scoping review

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To cite: Maguele MS, Taylor M, Khuzwayo N. Evidence of sociocultural factors influencing intimate partner violence among young women in sub-Saharan Africa: a scoping review. *BMJ Open* 2020;**10**:e040641. doi:10.1136/bmjopen-2020-040641

► Prepublication history for this paper is available online. To view these files, please visit the journal online (http://dx.doi.org/10.1136/bmjopen-2020-040641).

Received 08 June 2020
Revised 15 October 2020
Accepted 19 November 2020

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ABSTRACT

Objective This study carried out a scoping review of research on intimate partner violence to determine the extent to which studies on sociocultural factors influencing intimate partner violence among young women (15–24 years) have been conducted, and how different geographical areas are represented. It also considered whether the methodologies used were sufficient to describe the risk factors, prevalence and health outcomes associated with intimate partner violence among young women.

Study design Scoping review.

Methods Online databases were used to identify studies published between 2008 and 2019. The Preferred Reporting Items for Systematic Review and Meta-Analysis guidelines by Arksey and O'Malley were used to select studies, and primary studies were assessed using the Mixed Method Appraisal Tool, V.2011. Thematic content analysis was used to summarise the findings of the scoping review.

Results The majority of publications eight (61.5%) reported cross-sectional studies, while four (31.5%) were qualitative studies. One of the studies (7%) collected measured data. Overall, 13 (100%) of the publications examined factors influencing intimate partner violence. Using a customised quality assessment instrument, 12 (92.3%) of studies achieved a 'high'-quality ranking with a score of 100%, and 7.7% of studies achieved an 'average' quality ranking with a score of 75%.

Conclusions While the quality of the studies is generally high, researches on sociocultural factors influencing intimate partner violence among young women would benefit from a careful selection of methods and reference standards, including direct measures of the violence affecting young women. Prospective cohort studies are required linking early exposure with individual, sociocultural and community factors, and detailing the abuse experienced from childhood, adolescence and youth.

PROSPERO registration number CRD42018116463.

Scoping protocol publication https://doi.org/10.1186/s13643-019-1234-y

Strengths and limitations of this study

- ► We conducted an exhaustive search for relevant studies from five search engines, and after that the screening of abstracts and full articles was performed using a structured tool. The degree of agreement calculations revealed no significant difference, and the mixed methods tool was applied to assess the risk of bias.
- ► The review limited the findings to compare risk factors specific to younger women aged 15–24 years, as data on sociocultural factors influencing intimate partner violence were mostly derived from studies using existing studies in women of reproductive age.
- ► The use of a cross-sectional design in the included studies and use of self-administered questionnaires in accessing the experiences of intimate partner violence runs the risk of potential bias in the studies included, in respect of the study sample selection, the recall period and in obtaining socially desirable responses.
- ► There was a scarcity of research evidence regarding the sociocultural factors influencing intimate partner violence among young women aged 15–24 years in the sub-Saharan African settings.

INTRODUCTION

Intimate partner violence (IPV) is a widespread global public health concern.[1] According to UNESCO (2015), 85% of the violence against women is perpetrated by their male intimate partners.[2] The WHO estimates that globally one in three women (30%) experiences violence from their partners.[1] The prevalence in young women aged 15–24 years is high, ranging from 29.4% to 31.6%, while the prevalence in older women above 24 years ranges from 15.1% to 37.8%.[1 3] In the sub-Saharan Africa (SSA) region which carries the most substantial burden of IPV, (36.6% of the global estimates), the prevalence among young women aged 15–24 years, ranges from 19% to 66%.[3] Although the data are scarce in low-income and middle-income countries, (including SSA countries) regarding the IPV in young people, where the data are available the evidence points to

increased vulnerability to IPV among the younger groups of women compared with those older. For example, a recent study conducted in low-income and middle-income countries including SSA found that female adolescents and younger adults of 15–19 years were at higher risk of IPV when compared with older groups of women.[4] This pattern was mostly observed in Namibia, Senegal, Zimbabwe, Cameroon, Sierra Leone, Congo, Zambia and Rwanda. However, different patterns regarding the higher risk of IPV in older rather than younger women were found particularly in countries outside SSA such as in Europe and Central Asia.[4]

Globally, the numbers of young women are increasing. Worldwide, there are about 880 million women aged 15–24 years who constitute 12% of the world population.[5] Mostly they are living in developing countries, including countries from the SSA region.[5]

It is young women in this age group who are the population group that is mostly affected by social and economic inequalities leading them to be potentially vulnerable to violence including IPV.[6] For example, the high rate of unemployment affecting this group decreases their autonomy in making important decisions about their lives.[7] Around 80% of young women in SSA countries cannot decide about their own health, which limits their access to health services and therefore, to prevent IPV.[6]

In SSA many young women, although they may be living in their parents' households and not in cohabiting relationships, initiate sexual relationships at an early age.[3 8 9] The harmful social norms and the acceptance of the dominant role of men in society also perpetuate gender inequality to the detriment of women.[4 10] Young women in SSA are further affected by high-risk behaviours including risky sexual behaviour and violence, including IPV and their dating older partners increases their vulnerability to IPV.[11 12] Authors focusing on gender-based violence research argue that young women who are dating older men are unable to take control of their relationships.[11 13] An example of this is that of young women who, if they want to use protective measures such as condoms and contraceptives, must get approval from their older partner, who are not always willing to use such protective measures.[11] In addition to these risk behaviours affecting this group, various other specific and contextual risk factors including parents' and peers' influences, and the use/abuse of alcohol and drugs might influence their vulnerability to partner violence.[3 14]

The problem of IPV among young women is thus of concern and deserves immediate attention in order to mitigate such violence, since this group of women is still developing, and the negative impact of IPV is likely to compromise their lives and future well-being.[15 16] The factors that influence IPV among young women are well documented in developed countries, particularly in the US settings, and this includes economic, psychological, physical and cultural factors, but there is less evidence available from SSA settings.[17–19] The main challenges to the prevention of IPV among this population are therefore: first, little is known about the sociocultural factors that contribute toward IPV in young women who, although still living at home, may be in violent relationships.[8 20] Instead, research is mainly focused on household surveys aimed at measuring the prevalence of domestic violence in adult and ever married women.[1 4] Second, due to the community acceptance of violence and social norms of male dominance, the young women's risk of violence is often not addressed.[4 10] Third, the policies, law enforcement, reduction and prevention strategies are more focused on domestic violence in ever married or cohabiting woman, with little attention to the circumstances of young women experiencing violent relationships.[21] Understanding how these factors influence IPV in young women is necessary to better inform policymakers, health sector programmers and other relevant sectors for tailor-made interventions for prevention and reduction of IPV among young women.

This study thus, aimed to map existing evidence on sociocultural factors influencing IPV among ever partnered young women aged 15–24 years, in SSA.

IPV for young women is defined in this study as an act of physical, sexual and/or psychological/emotional threats or such harm by a current or former spouse/husband, a dating partner, an ongoing sexual partner, whether or not cohabiting, against the female partner.[22]

METHODS

Patient and public involvement

No patient involved.

Protocol and registration

The authors undertook a scoping review of the sociocultural factors influencing IPV among young women in SSA as part of a broader study aimed at investigating the sociocultural factors influencing IPV among young women aged 15–24 years in Maputo city, Mozambique.

A scoping review is a method undertaken to determine the value and scope of a full systematic review, and is useful to summarise and disseminate research findings, to identify research gaps and for determining the need and recommendations for future research. Scoping reviews are therefore of particular use when a body of literature has not yet been comprehensively reviewed.[23]

To capture a more complete range of relationships, we considered not only cohabiting young women but also ever partnered young women (young women who have ever had an intimate partner, and ever experienced partner violence). An intimate partner was defined as any male partner with whom the young woman has or ever had a romantic relationship since the age of 15, which included having sexual activities, whether spouse/husband, boyfriend/dating partner or ongoing sexual partner/occasional partner.[22]

The scoping review protocol was developed and published in BMC systematic reviews and is

Table 1 Framework for determining the eligibility of research questions (PCC)

Criteria	Description
Population	Women aged 15–24 years
Concept	Sociocultural factors associated with IPV (physical and/or sexual and/or emotional/psychological violence) and/or domestic violence
Context	sub-Saharan Africa

IPV, intimate partner violence.

available via the following link: https://doi.org/10.1186/s13643-019-1234-y.

The review was guided by the scoping review framework. It conformed to the Preferred Reporting Items for Systematic Reviews and Meta-Analysis extension for scoping review guidelines in presenting the results of this scoping review (Arksey and O'Malley).[24] Briefly, the framework involves (1) identifying the research question, (2) identifying relevant studies, (3) selection of studies, (4) charting the data, and (5) collating, summarising and reporting the results. Quality assessment of the included studies as recommended by Levac *et al* was also performed.[25]

We determined the eligibility of articles to answer our research question for a scoping review study using the Population, Concept, Context nomenclature presented in table 1.

Sources of information and search strategy

A primary search of research articles published in peer-reviewed journals, review articles and grey literature was conducted from the following databases: PubMed, CINAHL with full text, MEDLINE with full text, Health Source: Nursing/Academic Edition, Google Scholar (advanced search) and Academic search complete. Reference lists of the obtained studies were also searched to identify studies that could be added to the review. The search was guided by the following keywords: "intimate partner violence", "factors influencing intimate partner violence", "socio cultural factors", "dating violence", "domestic violence", "prevalence of intimate partner violence", "young women". Boolean terms (AND and OR) were used to separate the keywords and the use of Medical Subject Headings terms was also included during the search. The search was limited to studies from SSA, that were published in any language, for the 10-year period 2008–2019.

Study selection

Studies could include older women, but to meet inclusion criteria they needed to include some women aged 15–24 years. Therefore, studies were considered eligible if they met all the following inclusion criteria:

- Studies reporting evidence of the prevalence of IPV in adult women which included women aged 15–24 years.
- Studies reporting evidence on sociocultural factors influencing IPV against women.
- To be included the studies needed to have evidence of at least one type of IPV. There should be an evidence of physical, or sexual or psychological violence or co-occurrence of two or all forms of IPV.
- Study design: quantitative, qualitative, mixed methods, randomised controlled trial, cohort study, case–control study and cross-sectional study.

However, studies were deemed ineligible if:

- Studies do not report on the outcomes of the study.
- Studies were published before 2008.
- Studies examining IPV among same-sex partners.
- Studies reporting evidence on factors influencing IPV only in women above 24 years.
- Studies were not done in SSA.
- Review articles.

Following the previously outlined stages of the study selection and guided by our eligibility criteria, first, we conducted a title screening, whereby one reviewer (MSM), screened the titles from the databases. Eligible titles for abstract screening were then exported to the EndNote Library. All the studies that did not address the research questions were excluded together with all the duplicates. The reviewer sought and obtained assistance from the UKZN library services for articles that were difficult to find. The reviewer also contacted the authors to request full copies of the included articles that were not available via the databases and the UKZN library. The final EndNote database was shared among the review team for abstract screening. At this stage, two independent reviewers screened the abstracts (MSM and NP), guided by the eligibility criteria. Discrepancies between the reviewers' responses at this stage were resolved by discussions until an agreement was reached. At the third stage, the two reviewers independently screened the full articles (MSM and NP). Discrepancies between the reviewers' responses at the full-article screening stage were resolved by involving a third reviewer (NFT). The copies of the complete articles for the eligible studies were kept for data extraction by the two reviewers (MSM and NP). Lastly, a Kappa statistics' calculation was performed to determine the degree of agreement between reviewers at the full-article screening by using Stata V.13 software (Stata-Corp, College Station, Texas, USA).

A flow diagram of the study selection in figure 1: The Preferred Reporting Items for Systematic Reviews and Meta-Analyses 2009 flow diagram to update screening, updated from Moher *et al*[26] shows the process involved in obtaining the eligible studies.

Quality assessment

The Mixed Method Quality Appraisal Tool (MMAT), V.2011 was used to examine the quality of articles to determine the risk of bias.[27] The tool was used to investigate

2221

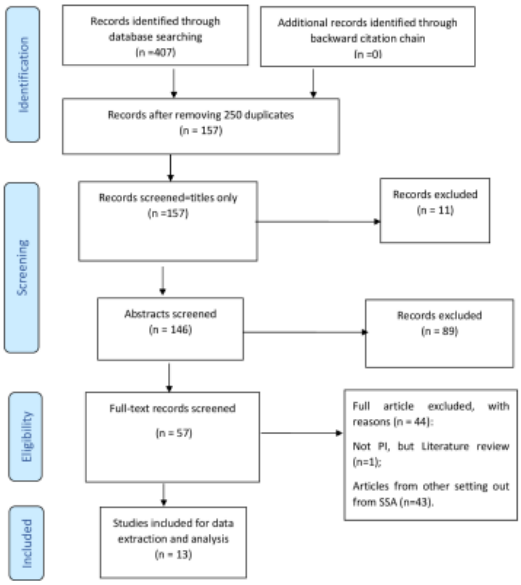

Figure 1 The Preferred Reporting Items for Systematic Reviews and Meta-Analyses 2009 flow diagram to update screening. Source: Moher *et al*, 2009. PI, Primary Investigation; SSA, sub-Saharan Africa.

the relationship between the theme and the research questions. Two reviewers (MSM and NP) assessed the quality of evidence of the included studies. The studies were evaluated in terms of the following domains: 'clarity of the research questions, relevant resources to address the objectives, relevant process of data analysis, the relationship between the findings and the context, and the relevance of the findings'.[27] An overall quality percentage score for each of the included studies was calculated. Scores were described as low quality (25%), fair quality (50%), average quality (75%) and good quality (100%). The quality scores in this study are reported in the Results section.

Data extraction

The information addressing the research questions was thoroughly extracted using a standardised data extraction sheet from the following domains: 'author and year, study setting, population, gender, intervention, the aim of the study, study design, outcomes and key findings'.

Collating and summarising the findings

In this study, thematic analysis was found suitable for the purpose of identifying sociocultural factors influencing IPV among young women from the included studies.[28] NVivo V.11 was used to extract the following relevant emergent themes: being younger than partner, education level discrepancies between partners, being married, employment and economic status of women, alcohol use by male partner, history of violence in both partners, sociocultural norms, environment and legal systems.

RESULTS

Screening results

The screening results for this scoping review are presented in figure 1. A total of 13 records were deemed eligible for data extraction and analysis. Degree of agreement was calculated after full-text screening. In respect of the full-article screening, there was 96.49% agreement versus 64.73% expected by chance between screeners, which constitutes a satisfactory agreement (Kappa statistic=–0.90 and p value of <0.05). In addition, the McNemar's X^2 statistic indicates that there is no statistically significant difference in the proportions of yes/no answers by reviewers (p value of >0.05).

Characteristics of included studies

Thirteen out of the 57 reviewed articles were eligible for data extraction. The total sample size was 13 334 participants, ranging from studies with 8 to 4906 participants, with the ages ranging from 14 to 56 years. Ten of the included studies had exclusively female participants, and in three studies, there were both women and men. The women comprised 12 322 participants, corresponding to 92.4% of the total sample size. The characteristics of the included studies are presented in table 2 below.

Risk of bias within studies

All 13 included studies underwent a methodological quality assessment using the MMAT V.2011.[27] Twelve out of the 13 included studies were scored as high quality with a score of 100%.[13 17 19 29–37] The remaining study had an average score of 75%.[38] None of the included studies was scored as low quality (25%). The overall evidence was considered to have a minimal risk of bias.

Summary of the findings

Evidence on sociocultural factors influencing IPV among young women in SSA was found in 13 studies and is presented under the following themes: being younger than partner, education level discrepancies between partners, being married, employment and economic status of women, alcohol use by male partner, history of violence in both partners, sociocultural norms, environment and legal systems.

Being younger than partner

Four studies reported that age discrepancies between women and their partners were a factor that influences IPV. The age discrepancy between partners was found to be associated with IPV both in a study conducted in South Africa among pregnant and postpartum women,[31] and in a study conducted in a general population of women from rural and urban communities in Nigeria.[29] In a Tanzanian study which aimed at describing and comparing the baseline prevalence of IPV among men and women, being young was associated with being both a perpetrator and

Table 2 Summary characteristics of included articles (n=13)

	Number (% of total studies)
Publication year	
2008–2011	4 (30.8)
2012–2015	6 (46.2)
2016–2019	3 (23)
Location	
South Africa	2 (15.4)
Kenya	3 (23)
Nigeria	2 (15.4)
Tanzania	2 (15.4)
Mali	1 (7.7)
Botswana	1 (7.7)
Rwanda	1 (7.7)
Togo	1 (7.7)
Setting: urban versus rural	
Urban settings	4 (30.8)
Rural settings	3 (23)
Both urban and rural settings	6 (46.2)
Setting—sector	
Colleges	1 (7.7)
Healthcare centre	4 (30.8)
Households	7 (53.8)
Services support centre	1 (7.7)
Design	
Cross-sectional studies	8 (61.5)
Qualitative studies	4 (30.8)
Longitudinal	1 (7.7)
Collection of data (methods)	
Questionnaires	9 (69.3)
Interviews	3 (23)
Focus group discussion	1 (7.7)
Topics investigated	
Prevalence and factors predicting IPV	7 (53.8)
Meanings and factors influencing IPV	4 (30.8)
Health consequences of IPV	2 (15.4)

IPV, intimate partner violence.

a victim of violence.[36] The age differences between partners were a reported predictor for IPV in a qualitative study from Botswana.[15] If a young woman is married to, or in a relationship with a partner older than herself, she may struggle to air her opinions about their relationship, and further the older partner may expose the younger female partner to violence.

Education level discrepancies between partners

Findings are divergent regarding the educational level and its association with IPV across countries. For example, in a study from Togo, educated and young female partners were more likely to experience IPV. The findings suggested that the women with grade 7–10 education were 1.5-fold more likely to experience IPV compared with their counterparts with no education.[34] Studies from Kenya, Tanzania and Botswana similarly suggested that a high level of education placed women at increased risk for psychological abuse.[17 35] In a study from Botswana, the unequal standard of knowledge between partners put young women at risk of violence, as the male partner might feel inferior and inflict violence to demonstrate that he is still superior even with a low level or without any education. In contrast, one study conducted in an urban region of Kenya aimed at evaluating the association between acceptance of IPV and IPV victimisation, suggested that young women with a high level of education were less likely to accept IPV.

The women's married status

Four studies reported marital status as a risk factor for IPV among young women. In one study, being married and having children rather than having no children influenced the young women's decision to remain in a marriage with violence.[33] In one of these studies, being married was linked to the risk of IPV.[19] While the other study that reported agreement between the idea that it is the women's duty to sustain the duration of the relationship, found that this was significantly associated with acceptance of IPV.[17] One study has reported that being in a formal marriage influenced young women to remain in a relationship with violence. The wedding vows taken on a legal marriage are binding for them and for them marriage is forever.[13]

Employment and economic status of women

Three studies reported the status of employment and low economic situation as a factor associated with IPV in young women; however, the type of violence varied according to employment status.[13 17 36] In a study from Tanzania aiming at describing and comparing the baseline prevalence, overlap and risk factors of psychological, physical and sexual IPV, the study findings suggested that young women who were not employed reported more IPV.[36] While in a study from a rural area of Botswana which aimed at evaluating the association between acceptance of IPV and reported IPV victimisation, the study findings suggested that employed and educated young women were more likely to report psychological rather than physical abuse.[13] Whereas in a study conducted in South Africa and Tanzania, reports of economic deprivation, individual level of poverty, inability to meet daily needs and living in nations with lower gross national income were predictive factors for IPV. Thus, the study's findings suggest that young women who were economically dependent or lacked sources of survival and were not owning a

place to live were more likely to remain in a relationship with violence, since their partners were their main financial and subsistence source.[17] A study conducted in a rural setting of Kenya reported that poverty and dependence were factors that hindered young women from leaving or prosecuting a violent husband, who provided the food for the family.[35] There is limited research aimed at investigating economic status of young women as a risk factor for IPV in SSA setting.

Alcohol use by male partner

Three studies reported alcohol use to be associated with the risk of IPV. Alcohol use by a male partner was related to attitudes of controlling behaviour and with increased risk of IPV in young women in a study conducted in an urban area of Nigeria.[29] Similarly, findings from a study by Hayes and van Baak linked alcohol abuse by a male partner to the risk of sexual and physical violence.[32] The risk of IPV among those who have ever consumed alcohol was due to the negative impact of alcohol consumption, since alcohol abuse is deemed to reduce responsibility. Therefore, men use alcohol to exert power over women. In support of this, a study conducted in an urban area of Tanzania by Mulawa *et al* revealed that among men, having ever consumed alcohol was significantly associated with the risk of perpetrating IPV.[36]

History of violence in both partners

Six studies reported on previous exposure by the women to violence and IPV victimisation. The findings of these studies suggested that women who have ever been exposed to any type of violence or who have ever witnessed violence in their life were more likely to report IPV in their current relationships. One study also revealed that having a partner who has ever been involved in previous physical fights with other men was the risk factor for IPV victimisation in young women.[32] Another study suggested that young women who have been involved in violence in past relationships were more likely to report IPV in their current relationships.[19] One study indicated that young women who have ever perpetrated violence in a previous relationship were at higher risk to commit and to experience IPV in their current relationship.[34] Three studies reported on a childhood history of violence, in that either witnessing a parent's violence or being a victim, was associated with the increased risk for IPV victimisation.[13 35 36]

Social norms

Most of the studies in this review (8 out of 13) reported on social norms which emphasise male dominance as a risk factor for IPV. Studies linked cultural practices and social norms with increasing risk of IPV in young women.[19 31–35 37 38] Whereas attitudes to young women as subordinate and male dominance within relationship were reported in three studies.[19 35 38] Attitudes of young women's acceptance and their justifying violence as a husband's right were also noted in three studies,[19 35 37] while attitudes of men's controlling behaviour to young women were reported in one study.[32] Acceptance of cultural practices such as polygamy was reported in one study.[33] Practices of bride price or lobola; changing one's name and relocating to men's residence were reported in one study,[13] and attitudes regarding religion commitment were reported in one study.[34] The cultural context and the existing harmful social norms in SSA affect also young women and may help to explain the burden and recurrence of IPV in this setting. There is limited research aimed at investigating social norms as a risk factor for IPV among young women in SSA.

Environment and legal systems

Three studies reported on violence in the community and the political systems and the women's responses to IPV. For example, a study from Togo revealed an increasing risk of IPV in young women in communities where violence is not condemned.[34] In another study aiming at investigating the lived experience of women in Botswana who had experienced emotional abuse from a partner, the findings suggested that young women who were from a specific ethnic group reported more IPV. In those communities, emotional abuse was not considered abuse as it falls under the dictates of local culture.[13] While studies from Tanzania and Rwanda among women who have ever experienced IPV reported on the weakness of governmental laws regarding IPV, as factors that influenced the young women's decision whether to prosecute the perpetrator or to remain in a violent relationship.[19 36]

DISCUSSION

Main findings

This study sought to map evidence of the sociocultural factors influencing IPV among young women in SSA and to identify the research gaps. The search was restricted to studies published from January 2008 to May 2019. We included in our review all papers accessing physical, sexual or psychological violence, perpetrated by an intimate male partner against the female partner. The studies could include older women as well, but to meet the inclusion criteria they needed to also include and provide data on women aged 15–24 years. Knowing that studies concerning women experiencing partner violence often use different methods and definitions to address IPV, we included in the definition of IPV the designations for women aged 15–24 years attributed by others, such as domestic violence/husband abuse/partner abuse or dating violence. Thus, the included studies used different methods, definitions, different timing/frequency and measures of IPV. For example, some studies considered women at risk of IPV to include only ever married/cohabiting women,[13 32 36 37] other studies considered currently partnered women[19 31 38] and ever partnered women.[17 29 30 34 36] Therefore, this discussion applied not only to cohabiting women but includes ever partnered woman who has ever had an intimate partner, and ever experienced partner violence.

IPV occurs globally despite the actions that have been taken to prevent it in most countries. Therefore, the findings of this study have helped to underscore better the existing evidence on the sociocultural factors influencing IPV among young women in SSA. Bearing in mind the reported high prevalence and the sociocultural factors influencing the practices of IPV among young women in SSA that emerged from this review, these findings pose a global health concern regarding the need for countries to achieve the Sustainable Development Goals 5.[39] Regarding this global concern, the WHO emphasises the need for research and evidence-based information to support education programmes and strategies empowering girls in skills to challenge social norms in the context of SSA where the prevalence of IPV is alarming.[40 41] Moreover, a recent review aimed at evaluating what works, concerning interventions to prevent violence against girls and young women in low-income and middle-income countries, (which includes most of the countries in the SSA region), revealed the need for multilevel interventions to address young women.[8] Responses should be based on community engagement to enhance their social network resources and promote women's agency, and encourage role models. The review has contributed to the required evidence-based information to provide the scientific basis needed to address sociocultural factors influencing IPV against young women in SSA. To the best of our knowledge, our study is the first scoping review of the sociocultural factors influencing IPV among young women aged 15–24 years in these settings.

It is noted that the prevalence of IPV as reported in this study differs from that from the studies from some high-resource regions, such as the USA where the overall reported prevalence of IPV in young women was not as high and was estimated at 8%–51.2%.[42–44] The prevalence of IPV reported in our review was much higher ranging from 28.77% to 67%, and was similar to the one reported in a study conducted among young women aged 15–24 years in SSA and elsewhere, where the prevalence ranged between 19% and 66%.[3] These results show that IPV among young women is common in many countries in the world but varies according to countries and regions. However, it is much higher in the SSA region, where governments are struggling to find the resources to provide effective preventive programmes to reduce IPV among young women.[18] These differences in the prevalence of IPV, reported in our study, could be due to the differences in methods, differences in the effectiveness of the health services responses, differences in the health education strategies, as well as differences in the compliance with regulations and laws on violence against women and even the cultural differences within countries.

Our review reported that childhood exposure to violence, previous experience of IPV, either witnessing parents' violence or experiencing childhood violence, are risk factors for IPV. Findings from our review regarding these life course factors are also consistent with those reported in studies conducted in the USA.[42 45] Further in a study by Al-Modallal, which examined the risk of partner physical violence victimisation as a function of childhood maltreatment among college women in Jordan, the findings revealed that the risk of severe physical partner violence was three times greater among women who had experienced childhood physical violence and five times greater among those who had witnessed father-to-mother violence.[44] The review confirms the theoretical model which hypothesises about the relationship between the children's exposure to violence and the risk for IPV. The likelihood of experiencing IPV among women who have ever been exposed to violence in childhood might be through the mechanism of their lacking in coping skills. This may lead them to engage in violent methods when resolving conflicts, rather than non-violent conflict resolution methods. Another reason may be through the influence of their parents or their parents' modelling behaviour. Children may learn violent behaviour from their parents and might then imitate or replicate the behaviour from adulthood and across their lives. We highlighted similar findings from two studies carried out in South Africa among grade 8 learners, where the factors associated with girls' experience of IPV included childhood experiences of violence such as corporal punishment at home, school or community, and witnessing parents' violence.[9 46] These findings, therefore, highlight the importance of starting prevention efforts early in childhood, by adding in prevention strategies' programmes that may build their skills and abilities to negotiate and engage in safe relationships.

In this review, findings revealed the use of alcohol by the partner and the young age of female partner as factors that are associated with IPV. Consistent with a study by Brown *et al* among a clinical sample of young people aged 15–24 years, the findings revealed that physical dating violence against women was associated with poorer psychosocial functioning and the substance dependence of the partner.[47] Another study by Collibee and Furman reported on alcohol use as a factor associated with the increase in dating aggression among young people.[48] Kelly *et al*'s study, which assessed the attitudes, self-efficacy and occurrence of dating violence, revealed a significant association between such violence and risk factors. These comprised the early initiation of sexual experience, drug abuse, unwillingness to engage in the initial sexual experience and inability or low self-efficacy to prevent abuse with IPV victimisation.[49] Alcohol use is suggested to have an influence in reducing one's sense of responsibility and thus people engage in risky behaviours, including IPV and other forms of violence. This is in concordance with the findings from a study among adolescents' grade 8 learners in South Africa, which reports an increased risk of IPV among those adolescents using alcohol.[9 50] It is hypothesised that the use of alcohol among men may lead them to use negative styles to resolve conflict through their limited ability to use non-violent conflict resolution methods. Moreover, men might persuade young women to engage in alcohol drinking with an expectation that

young women will then welcome sex and then use force if they do not agree to engage in sexual activity.[46] Widespread alcohol consumption and its connection with violence among young people has been in the spotlight of research in SSA and US settings. It is thus crucial to tackle alcohol use and its association with violent attitudes when implementing IPV programmes among young people and thus to teach young women to recognise and to avoid engaging in such violent relationships.

Although cultural differences exist between settings, IPV is a broad phenomenon that prevails worldwide. Our review findings reported on gender inequalities, cultural practices, and the community and legal systems associated with increased risk of IPV.[13 32 35] In support of our findings are the studies from the US settings.[45 49 51] For example, Straus and Gozjolko, in a study which analysed 13 877 university students who were in dating relationships, reported that attitudes of coercive control of women by men are associated with increased risk of IPV.[51] Similarly, the prevailing patriarchal norms of male dominance influence the relationship dynamics among the Maori women and also shape their decision of remaining in a violent relationship.[52] Recent studies from Bangladesh and Vietnam highlighted persistent social norms of male dominance that are still prevailing in those societies.[53 54]

The findings from our review emphasise that IPV remains a burden across countries and continents, especially in SSA. It appears that cultural differences between settings may explain the differences in rates, types and responses rather than the occurrence of IPV. For example, the study among grade 8 learners in South Africa reported a reduced risk of emotional violence among women who disagreed with the ideologies of male dominance.[46]

However, disagreeing with partners or arguing might increase the risk of physical violence among those partners who use violence to resolve conflict or those dating partners with strong ideologies of male dominance.[9] Prevention programmes would need to challenge these ideologies in a safe environment and to raise awareness about non-violent ways of resolving conflicts between young partners. Moreover, a longitudinal research is needed to determine whether protective factors work in mixed or separated gender groups. Thus, the effective interventions will need to tackle empowering girls with skills to challenge negative social norms, and to tackle policies and law enforcement that condone all forms of violence against women from childhood across their lifespan.

The findings from this review have confirmed the contribution of factors at the individual, sociocultural and community levels that influence IPV among young women in SSA. This review has also provided additional evidence on the contextual sociocultural factors that may increase young women's vulnerability to IPV in the setting of SSA. The particular findings reported on cultural practices of polygamy, payment of lobola for marriage, involvement with older men, changing the name of the woman who relocates to the man's residence, and childhood experience of violence, including attitudes to child punishment, increase the current information by providing a unique context of the sociocultural factors placing young women at increased risk of IPV in SSA. These traditional practices still prevail in most countries in SSA and contribute to IPV behaviours. In contrast, sociocultural factors are less common in developed countries outside SSA such as the US setting where the researches on IPV among young women are often conducted, and the typical findings are related to whether the young women have witnessed or experienced IPV during childhood, their having multiple partners, and the use of drugs and alcohol among young people.

Given that the contextual factors which have emerged often constrain the existing strategies aimed at reducing IPV among young women in SSA, new approaches for addressing young women in SSA should be added to the current interventions. Therefore, additional efforts are necessary to increase young women's ability to challenge harmful social and cultural norms, and to build their skills to avoid their engagement with older partners and in violent relationships. There is also an urgent need for those in such relationships to enhance their ability to decide whether to remain and manage such violent relationships or to have the option to leave.

Although the research on sociocultural factors influencing IPV among young women is reported less in the SSA setting, our review is noteworthy of several contributions. This review has first contributed to the body of literature by examining, comparing and synthesising the studies' findings on the evidence of the factors influencing IPV against young women across multiple forms of IPV in SSA countries. Second, our review provided quantitative and qualitative data, regarding factors influencing IPV among young women in SSA, and this has been underlined by the rigorous standards, criteria and methodology used in this review process. This has helped to examine the emerged individual, sociocultural and community factors that show promise to guide the design of contextual and effective preventive interventions addressing young women in SSA. Finally, the review emphasises the sociocultural factors placing young women at increased vulnerability of IPV in SSA. In this setting, the majority of communities are dictated to by the social norms which give privilege to men's dominance over women, leading to gender inequalities and promoting IPV, which needs to be targeted. This synthesis is important, given the focus of the research on young women, a group that is most affected by gender inequalities resulting in higher risk for IPV. Due to the harmful social norms that still prevail in SSA and the limited research on factors influencing IPV among young women, there is still a need to provide additional research on other sociocultural factors affecting young women such as peer pressure, parental influences, socioeconomic and educational background of parents, in order to adequately contribute to effective intervention programmes to reduce IPV among young women in SSA. Such programmes to reduce IPV among this vulnerable

population group should be initiated early, using contextual and multilevel approaches to safeguard the physical, sexual and emotional well-being of young women.

Strengths and limitations

This study is a unique scoping review to map evidence on sociocultural factors influencing IPV among young women in SSA and to provide evidence-based recommendations, a topic for which few review studies exist outside America.

The scoping review methodology employed herein was detailed. We conducted an exhaustive search for relevant studies from five search engines. The screening of abstracts and full articles was performed using a structured tool. Then the degree of agreement calculations after full-article screening revealed no significant difference between the screeners' responses. The MMAT was applied to assess the risk of bias. However, despite the above-mentioned strengths, limitations regarding the study design of the included studies were encountered. Most studies were cross-sectional in design. There was also potential for bias in the studies included in respect of their selection of the study sample and the recall period. Moreover, the evidence of IPV experiences was mainly assessed in most of the studies using self-administered questionnaires. This method runs the risk of potential recall bias in obtaining socially desirable responses.[55] Few studies were focused specifically on young women aged 15–24 years. Data on sociocultural factors influencing IPV among young women aged 15–24 years were mostly derived from existing studies researching IPV in women of reproductive ages, which included young women. This may have limited the findings to compare risk factors specific to young women. Thus, this highlights the need for more primary research focused on sociocultural factors influencing IPV among young women in SSA to contribute evidence-based prevention programmes to reduce IPV among this vulnerable population group.

CONCLUSION

Although unevenly distributed among SSA countries, the studies revealed considerable research evidence of the factors associated with IPV in some of these settings. Many of the studies that provided evidence about IPV among young women were carried out in the US settings, whereas few studies were from SSA. The findings point to the scarcity of research evidence regarding the sociocultural factors influencing IPV among young women in SSA. Nevertheless, IPV is a common phenomenon in SSA. It is mainly influenced by the factors interacting at the individual, community and societal levels such as young age of women, discrepancies in the education level between partners, young women's marital status, low economic/unemployment status of women, alcohol use by women's partner, history of violence including childhood violence experienced by both partners, social norms of male dominance, and environmental and legal systems. Understanding about the sociocultural risk factors for IPV among specific groups of young women in SSA will help to design contextual preventive programmes that contribute to the reduction of their vulnerability and the trajectories of victimisation from childhood and across the life course. Thus, effective prevention programmes should incorporate actions empowering young women economically and with education to enhance their awareness and autonomy, and develop their ability to challenge harmful social norms, allowing young women to pursue their relationships' lives with integrity and free from violence.

Implications for practice

Risk factors such as young age of young women, discrepancies in the education level between partners, young women's marital status, low economic/unemployment status of young women, alcohol use by young women's partner, history of violence including childhood violence experienced by both partners, social norms of male dominance, and environmental and legal systems are associated with IPV among young women and therefore constitute a public health concern. We recommend that health promoters and providers at health system facilities, including those at community and political levels, continue monitoring and providing health assistance and political and legal support for the victims. Action is also needed to empower young women concerning their awareness about IPV in a community-based approach.

Implications for research

This scoping review shows a gap in research focusing on sociocultural factors influencing IPV among young women in SSA. The existing few studies conducted in SSA, and most of the studies undertaken in SSA setting, are cross-sectional studies. The implementation of qualitative and longitudinal studies focusing on young women would be beneficial in providing more understanding of the factors underpinning IPV and guide proper preventive interventions.

Acknowledgements The Instituto Superior de Ciências de Saúde (ISCISA)—Maputo, Mozambique, the Netherlands Initiative for Capacity Development in Higher Education (NICHE) and the University of KwaZulu-Natal (UKZN)—Durban, South Africa, are acknowledged for the provision of resources toward this review. The UKZN Systematic Review Services is acknowledged for the provision of courses on Systematic Reviews methodology and participating in the screening process. The UKZN College of Health Sciences Library services is acknowledged for the workshops on database searches and provision of resources to conduct this research. NPV is acknowledged for participation in the screening process. NFT is acknowledged for resolving discrepancies between two other screeners and for the contribution in reviewing the manuscript and for adding on valuables inputs.

Contributors MSM conceptualised and prepared the draft proposal of the study under the supervision of MT and NK. MT and NK assisted with the manuscript redaction. MSM prepared the manuscript, and MT and NK reviewed it. Respectively MSM, MT and NK contributed to the reviewed draft version of the manuscript and approved the final version.

Funding The work is part of a large study that has been conducted by MSM with support of ISCISA in partnership with the Netherlands Initiative for Capacity Development in Higher Education (NICHE) and the University of KwaZulu-Natal (UKZN) College of Health Science as part of a PhD study conducted by MSM.

2229

Competing interests None declared.

Patient and public involvement Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement The majority of data relevant to this study are included in the article or uploaded as supplemental information.

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2231

CHAPTER SIX

MANUSCRIPT

Paper 3: Intimate partner violence: Views and perspectives of young women at Maputo-city secondary schools, Mozambique

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Status: Under review

Journal: Sage Open

Date submitted: February 23, 2021

Introduction

The findings from the review (Paper 2) indicated that there is limited evidence on IPV among young women in SSA, and further research is needed with different methods and reference standards. Also, that direct measures of the violence affecting young women are required. Although the review ascertained different geographical and contextual factors, we conducted an exploratory study to understand the contextual drivers of IPV amongst young women in the setting of Maputo, Mozambique. The study aimed to describe the young women's views and perspectives on IPV. The results contributed to a contextual framework for improving programs that would reach young women and address their needs to prevent IPV in Mozambique.

Doctoral student's contribution

I conceptualized the study with the guidance of the supervisors, Dr Nelisiwe Khuzwayo and Professor Myra Taylor. I did the data collection, data analysis and drafting of the manuscript. The supervisors critically reviewed the manuscript. All authors read and approved the final manuscript.

Intimate partner violence: views and perspectives of young women at Maputo-city secondary schools, Mozambique

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Abstract

Background: Intimate partner violence (IPV) among young women is a subject of serious concern due to the early age of occurrence. The study explored young women's views and perspectives about IPV in Maputo City.

Method: An explorative, descriptive qualitative study design was employed. Using purposive sampling, six focus group discussions, each comprising 10−12 female secondary school participants (66 women), was held at three secondary schools to gather data. The data were analysed using a thematic content analysis approach.

Results: From the analysis, in line with the socio-ecological model, the following four themes emerged: 1) (Individual level), related to knowledge of young women about IPV through witnessing friends being physically abused by their partners, from friends sharing personal experiences of IPV and experiencing the accepting attitudes of their mothers toward IPV; The meanings that young women give to the occurrence of IPV viewed as a violation of the human rights of women; The alcohol use a contributing factor for IPV and the economic status of women leading to acceptance of IPV. 2) (Relationship level) related to the influence of friends. 3) (Community level) related to religious beliefs that placed men at the head of the social order above women and 3) (societal level) related to factors promoting acceptance of IPV, and these included social acceptance of violence and the male chauvinism; The recommendations advocated by the young women to prevent IPV, and these included the promotion of awareness about IPV and the use of support services for the victims and the need to create specific IPV counselling centres for young women to meet their needs and to allow the counsellors to screen for other potential sexual and reproductive problems which affect young women.

Conclusion: There is a need to improve young women's skills to challenge the dominant male norms and enhance their autonomy to manage and end violent relationships. Community activities promoting gender-egalitarian norms and highlighting the positive role of mothers as models against IPV are needed, as is optimizing women's attitudes against the acceptance of IPV. Structural and political improvements are required to enhance the

opportunity to promote women's reproductive health and human rights to end gender-based violence and IPV in Mozambique.

Keywords: Gender; Women health; Violence; Youth; Human rights; Socio-cultural.

Background

Worldwide intimate partner violence (IPV) remains one of the most visible forms of violence against women. IPV has been deemed a global public health concern due to the negative effects on women's health and wellbeing [1]. Sub-Saharan Africa (SSA) is the most affected region globally, with recent estimates pointing to lifetime prevalence of IPV from 19% to 66% among young women aged 15 to 24 years [2, 3].

There is consensus that women exposed to IPV are at higher risk of experiencing adverse health outcomes [4]. These include the negative effects of unwanted pregnancy, abortions, and sexually transmitted infections, including infection with HIV, on their sexual and reproductive health [1]. IPV exposure is also associated with mental disorders such as suicide ideation and behavior, symptoms of depression, posttraumatic stress, eating disorders, injuries and even death [5]. Interpersonal violence such as IPV in the Sub-Saharan Africa (SSA) region contributes negatively to the economy. It is estimated to have reduced gross domestic product (GDP) by around 15% compared to a 3% reduction of GDP in high-income countries [6].

While the effects of IPV among women have been debated and researched by social scientists, economic, political and socio-cultural factors have also been identified as the cause for concern. Gender norms that give privilege to men's dominance over women, the acceptance of wife-beating and men's entitlement to sex have been identified as major socio-cultural factors underlying IPV [7, 8]. The construction of masculinity has been recognized as another negative influence on IPV. Additional studies conducted in Vietnam and Nepal suggest that the cultural construction of masculinity, were perceived as masculine superiority, may also contribute to gender inequalities, conflicts and partner violence within families and communities [9, 10].

Notwithstanding that research on IPV among older women above 24 years is common in developed countries, providing evidence on IPV among young women (15-24 years) has been challenging in low resource settings such as Mozambique. In this population group, adolescence or early adulthood is a period of physical and emotional transition. It is the

foundation stage where young women are likely to form or initiate relationships [11]. Therefore, the risk of IPV, exposure to IPV and its effects may be more severe than in older women [4, 11]. Moreover, the causes of IPV among this group of young women may differ from that amongst older women and be more complex, depending on the context.

For instance, in Mozambique, previous studies investigating IPV among young women have produced mixed results. A study using qualitative methods found that the group of participating women aged 15-19 years agreed that men could not control their sexual behavior [12]. Therefore, they believed that women must satisfy men's sexual desires at any time. A previous quantitative study showed a link between social norms and IPV, where one in four women justified the right of men to hit their partner in some circumstances. However, those young women justifying such violence were younger and experienced financial constraints [13].

This suggests an existing social acceptance of gender-discriminatory norms and the privilege of male dominance over women and young women's low gender empowerment attitudes. The existing sociocultural vulnerabilities among young women may result from the social context or environment where they are integrated, such as the community where they live, which may endorse strong ideologies of male dominance [51, 52].

The existing gender norms in families and communities in the Mozambique setting affect the socialization of young people and may influence the occurrence of IPV since women are socialized to accept and comply with the norms of perceived male superiority. Thus, they might accept the violence perpetrated by their partners [14, 15].

Understanding the underlying factors enabling IPV amongst young women is crucial to providing the evidence-based information to recommend contextual and early interventions for prevention.

Using a qualitative analytical approach, this study examined how young women learn about IPV; explored their views and perspectives about IPV, as well as the factors that promote the acceptance of IPV. These results contribute to the literature and the understanding of IPV in a developing country, which will help in the development of gender-based prevention

programs addressing young women, and towards the achievement of the Sustainable Development Goal 5 [16].

Methodology

Study area and Setting

The study was undertaken in the schools of Maputo city. There is a total of seven secondary schools in the area, but only three hold classes for grades 8−12. These take place in the day and the evening. Other secondary schools run classes from grades 8 to 10 for learners in the age group of 13−15 years. We selected secondary schools with grades 8−12 to enrol learners in the age range 15−24 years, who were the target group [19].

Design and population

An exploratory qualitative study design was used to conduct the study among learners in three secondary schools in Maputo. It is part of a more extensive study comprising both qualitative and quantitative methods to explore risk factors for IPV experienced by young women in Maputo.

All the female students aged 15−24 years, attending either day or evening classes in one of the three selected schools, were eligible to participate in the study. This age group was of interest because it is the period where many young women initiate relationships. Further, previous studies identified the group as having a high prevalence of IPV [13, 20].

Data collection

We selected Focus Group Discussions (FGDs) as the method of gathering data. FGDs are a useful method to explore the participants' perspectives, attitudes and experiences [21].

We used a non-probability purposive sampling approach to recruit participants. Before the discussion, potential learners at the school (15−24 years) were invited to a meeting that explained IPV and the study objectives and methods. Participants who volunteered to participate were scheduled for the FGDs. In total, 66 students, who constituted six FGDs, voluntarily attended. Only students attending day classes were willing to participate.

Before the discussion, the researcher emphasized the importance of confidentiality and anonymity of the information shared within a group. It was also explained to the participants that the transcripts and audio recordings would be kept anonymized by removing each person's name or any other identifying data and would be kept strictly confidential. However, participants were cautioned about the lack of privacy within the group and the limited confidentiality in sharing personal experiences.

The researcher advised the participants to rather discuss what they have learned and observed in their communities to minimise this. We thus conducted FGDs in the three selected secondary schools and to ensure geographical representation, and we held two FGDs in each school. Each FGD comprised 10−12 participants.

However, after the sixth FGD, the team stopped collecting data as they were no longer obtaining new information. The FGDs were conducted over six weeks between August and September 2019. The duration of each discussion was between 1.0 and 1.5 hours.

The discussions took place at the respective schools in a quiet room, as all participants agreed. The discussions were conducted in Portuguese, the official language of Mozambique, and the language most used in urban settings.

To facilitate the discussions, we used a FGD guide comprising the following topics. What are the factors young women perceive to be influencing IPV? Did the young women ever see or know someone who has experienced violence by a partner? The meanings and views regarding IPV and the general attitudes of young women to IPV were also discussed.

All FGDs were conducted by the first author, while a research assistant was employed to assist with the management of the audio recording and note-taking. The notetaking also helped with observing and capturing the non-verbal information. To validate the collected information, the research team held a short meeting at the end of each discussion to confirm the findings.

Data analysis

The data collected were analysed thematically, in line with the socio-ecological model[54]. An inductive approach was used to ensure that the themes were driven from the data collected, whereas the research questions drove the coding process.

A thematic analysis was selected as it allowed the researcher to identify the emerging themes from the data set, and these were used to further probe the views of young women in subsequent FGDs[55].

Applying the guide by Braun and Clark (2006), the thematic analysis comprised five steps [22]. Initially, the recorded data were listened to carefully and transcribed verbatim. The transcribed data were then translated from Portuguese to English and entered into NVivo V10 [23].

This software program was used to manage the textual data and maintain an audit trail. The team members read the transcripts from the FGDs and identified the repeated issues, considering not only the frequency but particularly the relevance for the research question, and at that point, codes were cited.

The codes were highlighted using different colours for the different codes in the transcripts. The team compared and discussed their codes and then reread these. The procedure continued through the extracts until consensus was reached. This procedure encouraged inter-rater consistency.

All the identified codes were then grouped to form themes. Subsequently, the themes were reviewed and compared back again to the transcripts to find all the relevant associated data and to map and interpret the whole dataset in a thematic map. Tables were drawn to organize the grouped codes and respective themes.

We ensured credibility by systematically using the original data, through, for example, documenting the quotations and these were used to present the results and the dependability and consistency of the findings, having identified similar themes which had been reported in the different discussions.

The Consolidated Criteria for Reporting Qualitative Research-COREQ was performed for maintaining the quality of the data [24].

Ethical considerations

Ethical approval to conduct the study was obtained from the University of KwaZulu Natal, Humanities Social Research Ethics Committee (HSREC) ref: HSS/2005/018D and from the National Health Bioethics Committee of Mozambique (CNBS) ref: 360/CNBS/19. Permission was obtained from the National Directorate of Education in Maputo and from the local Directorate of the respective schools.

All participants provided written informed consent voluntarily. Participants under 18 years of age provided written assent and written consent from their parents/guardians. No monetary reimbursement was given to participants for their participation; however, each group were offered a light lunch during each FGD session.

Participants were advised that the aim of the discussion was not to share their personal experiences but rather their perspectives concerning IPV and the experiences from their communities. There was the minimal risk that the study had the potential to bring back negative memories. Thus, participants were told to inform the researchers if this occurred, and the researchers offered to facilitate referral services for assistance if required.

No participant reported experiencing negative feelings as a result of the study. Although we used their names to identify participants during the discussions and the school names, they were subsequently concealed to guarantee confidentiality and anonymity.

Results

Characteristics of the Sample

In total, 66 participants contributed to the six FGDs, where the number of participants per group ranged from 10−12. All the participants were females between 15−22 years who were attending day classes. The participants' characteristics are presented in Table 1.

Table 1. Socio-demographics characteristics of the participants

Groups	**Number of participants**	**The age range of participants**
FGD1	10	16-20
FGD2	12	15-19
FGD3	12	17-22
FGD4	10	16-19
FGD5	11	17-19
FGD6	11	17-21

Themes

From the analysis, in line with the socio-ecological model, the following four themes emerged: 1) (Individual level), related to knowledge of young women about IPV through witnessing friends being physically abused by their partners, from friends sharing personal experiences of IPV and experiencing the accepting attitudes of their mothers toward IPV; The meanings that young women give to the occurrence of IPV viewed as a violation of the human rights of women; The alcohol use a contributing factor for IPV and the economic status of women leading to acceptance of IPV. 2) (Relationship level) related to the Influence of friends. 3) (Community level) related to religious beliefs that placed men at the head of the social order above women and 3) (societal level) related to factors promoting acceptance of IPV, and these included social acceptance of violence and male chauvinism; The recommendations advocated by the young women to prevent IPV, and these included the promotion of awareness about IPV and the use of support services for the victims and the need to create specific IPV counselling centres for young women to meet their needs and to allow the counsellors to screen for other potential sexual and reproductive problems which affect young women.

Individual-level

As shown below, young women's knowledge about IPV, the meanings that young women give to the occurrence of IPV, the use of alcohol, and the economic status of women emerged

as key individual factors that undermined the views and perceptions of IPV in this setting. These are presented below.

Young women's knowledge about IPV

All the participants considered themselves well informed about the phenomena of IPV. Their knowledge was orientated towards physical abuse by a male partner. There were three main sources from where young women learnt about IPV, and this influenced their knowledge about and attitudes to IPV. Friends had shared their experiences of IPV, but in addition, young women reported witnessing their friends being physically attacked and humiliated by their partners. The attitude of their own mothers toward IPV and whether or not their mothers experienced such violence also informed what they knew about IPV. Examples that were presented in the discussions are provided below.

Sharing of experiences of IPV by young women's friends

Most participants defined IPV as a common phenomenon that frequently occurs in their friends' relationships. They explained that their friends narrated incidents where they were abused by their partners. This appeared to occur frequently and was a topic reported in all the groups. The jealousy of the partners was the predetermining factor for violence. They described how men appeared to consider that they "owned" the young women and that their partners were not allowed any social contact with other males. For instance, some partners retaliated violently when their girlfriends received phone calls from male figures, whilst other partners became furious and used physical violence if their girlfriends were greeted by other males when they were together. The shared experiences of their friends were the most frequently mentioned form of learning about IPV, as they explained:

"My friend used to tell me that her partner normally attacks her… she said it was normal; when someone phoned her with a strange number, and he realized that the number isn't in her contacts, he used to phone back and when it was a man he slapped her". (Participant 1 from FGD 1)

"A friend, we grew up together. She told me that sometimes her boyfriend attacks her because she was greeted by another man and he didn't like that". (Participant 9 from FGD 4)

Witnessing friends being physically attacked by their partners:

Participants described situations where they witnessed their friends being abused by partners. Some participants saw their friends being beaten up by their boyfriends and other participants reported hearing their friends screaming and crying after being attacked by their male partners. The reasons for such attacks and the circumstances of such attacks resulted from the young women disagreeing with the partner and not complying with the partner's wishes, particularly with regards to having sex. The participants explained that seeing such behaviour was a way of learning about the phenomenon of IPV and seeing how prevalent it was in their society. One participant explained:

"…My friend would be invited by her boyfriend to his house; her boyfriend would want to have sex. If she declines, he beats her. …one day we witnessed that because she was at her boyfriend's house and when we arrived, we started hearing noises, she was screaming, and we realised that he was beating her…My friend showed up with bruises and bloodstains on her face. Her boyfriend attacked her with a cable". (Participant 4 from FGD 2)

The attitude of mothers toward IPV

Participants labelled their home environment as the place where young women initially learn about IPV. They mentioned that the attitudes and views of mothers toward IPV influence the knowledge about IPV among their children. Mothers were specifically singled out as role models for their daughters, and the attitudes of many mothers towards the acceptance of violence as normal, was seen as a cause for concern. According to the participants, if the mother experiences IPV and she accepts this as normal, and she does not take any action to prevent such acts, the girls learn from their mother's attitude and inherit what they have seen, and some end up assuming it is normal to be in an abusive relationship. Mothers' acceptance of IPV and lack of action to address this was therefore seen to have a critical role in that their response to IPV from their partners influenced how their daughters viewed IPV.

"If your father is beating your mother and later you date or marry an aggressive partner, you will find it normal, and you will remember that your mother experienced the same things when you were growing up, and your parents didn't divorce, and she never reported him". (participant 3 from FGD4)

In contrast, some participants described instances where the views of mothers meant that they

were positive role models against IPV since some mothers repudiate violence. They explained that independent and confident mothers who are able to disapprove and not tolerate violence convey a positive message to their daughters that such violence should not be accepted. This will encourage their young daughters to develop similar views and not accept the violence that their partners might perpetrate. A participant said:

"My mother is very independent, so I am very independent too. No man, including my father, has ever attempted to threaten my mother or attacked her, so she told me that she would never accept abuse from my father... I have been taking this with me, I don't accept abuse". (participant 8 from FGD3)

The participants as non-tolerant of IPV reported even mothers who were experiencing IPV. Some participants explained that some mothers who are exposed to violence *feel* that no one must accept violence. The awareness of the young women about the harmful effects of IPV and that it is not acceptable is thus raised, and young women are encouraged to look for partners of a different ilk who will not abuse them.

"My mother was abused by my father for a long time; I think that was ridiculous. She accepted to be beaten …because she didn't want to see us suffering the same. She used to tell us that violence is not good, and we should not accept violence for any reason". (participant 5 from FGD4)

The meaning that young women give to the occurrence of IPV is viewed as a violation of the human rights of women

Participants felt that abrogation of women's and girls' sexual rights compromises their human rights, especially for young girls, where most of the time, their partners force them to perform sexual activities. The common form of IPV that they related was sexual violence. Young women were forced by their partners to have sex, and this was a major concern reported in the different groups.

"When your partner beats you, and when he obliges you to have sex when you don't want it, it is a violation of your rights". (participant 7 from FGD 4)

Participants were concerned about their peers who lack knowledge about relationships and their right to decline sex. In such relationships, the young women may hope to gain status

and economic benefits. They mentioned that for such reasons, their peers date older men who are experienced in relationships. The participants felt that their partners in decision making overpower young women as they lack the power to make decisions about the relationship, and as such, they struggle to exercise their rights. This was seen as a significant problem limiting young girls' ability to avoid IPV. The young women lacked the skills to spearhead an argument and make informed decisions to prevent IPV, especially regarding sexual violence perpetrated by their partners. The participants mentioned that young women lack the confidence to confront their partners and feel obliged to fulfil their demands, no matter how toxic the relationship becomes. The myth that males cannot control their sexual urges was also a belief that was reported as prevalent amongst young women. A participant explained:

"A friend of mine she has an older partner and independently of her disposition, he obliges her to have sex with him; it's just a matter of him having the desire that they must do it; she is still suffering from that, but she says: 'if he wants to have sex with me it is because he knows, he is a man, I must attend. (participant 9 from FGD 6).

Alcohol contributes to IPV

IPV occurs as a result of alcohol consumption by both partners. Participants viewed the effects of alcohol as a potential contribution to violent behavior. There was a consensus among the participants of the negative effects of alcohol and that men use alcohol to gain more control over their partners. Young women, as the weaker sex, are powerless and are further humiliated and compromised due to this. One participant said:

"…when the man is drunk, he loses control, and he can beat and humiliate his partner, the man says: 'I'm a man, and you will never touch me or speak to me anyhow, you must understand that you are a woman, and you don't have power". (participant 8 from FGD 5)

Participants further discussed the risky behaviours affecting youth in societies due to the use of alcohol. Participants mentioned that nowadays, young women both prefer and are encouraged to consume alcohol, which promotes the loss of inhibitions, leading to risky behaviours including violence and undesirable sexual activities, such as unsafe sex. If they refuse, they are more vulnerable to IPV. A participant gave the following example:

"…In the 21st-century young people prefer to smoke, drink alcohol, something like that; at the end, because they are drunk, they are involved in fighting, unwanted sex, whatever". (participant 8 from FGD 3)

Further, the participants reported that young women are encouraged to drink alcohol by their partners, which leads especially to their sexual activities. Participants felt that girls are pressured to participate because they love their partner and do not want their partner to break the relationship, as one participant explained:

"Some young ladies only want to be in sexual relations no matter how bad these relationships are. For example, some young ladies accept drinking alcohol to perform sex and satisfy their partners. When it comes to sexual activities, the girls say, 'if I don't accept his behaviour, he will break up with me. It is not easy for that girl to take a decisive decision because she is deeply in love". (participant 7 from FG1)

The low economic status of women

The low economic status of young women featured as one of the critical reasons for acceptance of IPV. As young women growing up in a modern consumer society, they needed various items that they and their families could not afford. Transactional sex among young women was seen as the answer to accessing such commodities, as the male partner provided such. The participants considered that this situation was an enabler of IPV. Because the young women were not working, they believed that coping without a partner would not be easy for them. The participants explained that because the young women's partners buy food, clothes, and other things, women do not have a choice but to accept the violence their partners perpetrate. A participant clarified this perspective:

"…she has an older partner, and she relies on him for everything, things like food, clothes; she doesn't work; she does nothing; she accepts all the bad things he does to her even to be beaten… so yeah, that's it". (participant 11 from FGD3)

Relationship level

Influence of friends

Most participants revealed that friends play a role in shaping young women's behaviours in

their relationships. They explained the peer pressure that young women experienced and that young women are more likely to imitate their friends' and peers' actions. They further mentioned that when young women are faced with abuse in their relationships, they seek advice from their friends. Friends are more likely to advise them to maintain the relationship, which provides for their financial needs rather than helping them to solve the relationship problems and thus, the abuse continues. This was further explained by a participant who stated:

"…sometimes there is a will to break up, but when you go outside looking for advice from the friends, they say, 'keep fighting for what is yours' (laughter); this is what keeps the girl in the same situation, and they tolerate violence…because sometimes that advice fails to improve their situation". (participant 9 from FGD1)

There were also different viewpoints expressed. Some participants revealed that sometimes young women do not disclose the problems in their relationships to blind their friends and peers that all is well so that their social links can be accepted. They argued that young women portray only positive acts and messages on social networks. The participants describe social media as a platform for boasting and increasing young women's self-esteem, where they only share what they believe will be acceptable to their peers while behind the scenes, they are being abused by their partners. Hiding the truth from friends was seen by the participants as another way of promoting tolerance of IPV. A participant said:

"…Social networks influence a lot in our days because girls post everything of their relationship. Young women post positive messages and show what is acceptable to the world, it is like, 'yesterday I made a post saying that "he is my everything, my love, my whatever", and today I can't post unclear messages because the relationship has ended or he has beaten me,' yaa!!, girls also look at that side of showing off". (participant 5 from FGD4)

Community-level

Religious beliefs

Spiritual well-being is an essential element of health, and churches exist to provide this service. According to the participants in their communities, many types of churches promote spiritual health. Participants argued that churches could influence IPV perpetration by

promoting norms that require females to be submissive to their partners. They complained that these churches endorse religious beliefs of male superiority and use them in marriages. Participants reported pastors as living double standards since at home, they are perpetrators of IPV. Still, during church services, they are "*lovely".* They do this to the extent that some women in the church ask, "*who is the wife of the man of God"* (pastor), wishing that they were in her position. Some altered words like "*virtuous woman*". This reaction by the congregation may hinder women from recognizing abuse. It may enforce tolerance of violence, as one of the participants said:

"Almost all the churches which believe that a virtuous woman is the one who is submissive to her husband, who always obeys and respects her husband' influence this violence. (participant 6 from FGD6)

Societal level

Participants mentioned several factors that may promote young women's acceptance of IPV. They highlighted the societal norms that appeared to accept violence in the community and the social norms prevailing in their communities, reinforcing male superiority against women. Participants further recommended interventions that can be used to prevent IPV. These are further explained below.

Social acceptance of violence

In exploring the environment in which young women are situated, social acceptance of violence serves to entrench the vulnerability of young women further and promotes their/ acceptance of IPV. In the Mozambican context, interpersonal violence, including violence between partners, remains a serious problem. However, there are few available programs or actions that empower communities to work against this practice. Most participants reported that interpersonal violence is socially accepted in their communities and that the women who grow up in these communities are socialized to accept violence as a norm. Participants further explained that when young women see other couples fighting, and no action is taken to discourage such practices, they assume that such violence in a relationship is normal. The fact that violence perpetrated by other couples in the community was considered normative

behavior was the core of the problem influencing IPV in many discussions. Participants explained:

"There's always violence in the society…So there are young couples who abuse each other, they think it's normal because they see other couples fighting, so they also accept... violence nowadays is normal". (participant 8 from FGD5)

Another participant said:

"…There are also the girls that grow up on an environment of violence…a girl who grew up in such a situation is not surprised at being hit by a partner…she thinks that is normal because she has seen others being beaten and no one gets involved, it is normal for them". (participant 10 from FGD6)

Male chauvinism

Most participants argued that one of the socio-cultural factors that influence violence is prejudice perpetrated by men against women within their communities. They stated that social norms such as gender inequalities and male dominance perpetuate IPV. According to the participants, the following different cultural aspects prevailing in their communities reinforce male superiority over women. These aspects include machismo, males having multiple partners and the practice of lobola. These are further considered below.

*Machismo***:** Participants discussed masculinity, a concept of male chauvinism, which privileges males' dominance over women as an essential and negative cultural trait evident in society. This was seen as a concept accepted by both African and Portuguese traditions and thus a cause for concern, as it entrenched the status quo, which diminished the status of women. Most of the participants strongly believed that this issue influences IPV, as one participant explained:

"*In my opinion, what incites violence is chauvinism because men think that women should be submissive towards them and accept everything. For the man who grows up with this mentality of machismo, a woman should never have an active voice in the relationship, so if a woman refuses to follow the man's rules, she ends up being beaten". (participant 3 from FGD 3)*

*Male partners having multiple female partners***:** Although marrying more than one wife is one of the cultural practices accepted in many African societies, this was not considered acceptable by young women. The participants suggested that the male partner's involvement with more than one sexual partner is a form of abuse and reinforces the ideas of male superiority. Some participants mentioned that it is accepted as a social norm that a man can have multiple partners in their context, as males are said to have the right to date more than one woman. According to the participants, this behaviour is not acceptable, however, because when the female partner complains about feeling betrayed and cheated, this leads to quarrels and violence.

"…and whenever he betrays her, they quarrel, fight, and break for some time but again they reunite, and he does the same because he thinks it is his right to have many girls…people take it as normal relationships" (participant 6 from FGD 6).

"…That idea that the man is superior in the home, he's the one who has the right to go out, and party and the woman should be at home…so whenever she saw the partner cheating, people say 'she should keep quiet. I think that's where violence starts because the woman does not accept her partner when he is dating another girl and all the time they fight about this issue". (participant 7 from FGD 2)

*Bride price (lobola)***.** For most African families, including those in Mozambique, marriage is only official after the payment of the bride price, which is called lobola. Lobola is paid in different forms, including money and cattle, to the bride's family. Since the practice of lobola is very lucrative, the families are likely to follow this cultural practice, and this occurs especially in the south in the urban region of Mozambique, such as Maputo-city, where this is standard practice, as it is in neighbouring South Africa. Participants argued that this cultural practice influences IPV in that some men assume that since they are "buying" their wives, they can do whatever they want, including abuse. Some participants described unhealthy marriages, which should lead to divorce because of IPV, but this does not happen. According to the participants, some women are forced to remain in such marriages because their families have either used up the lobola paid to them or do not want to pay back the bride price. The most reported reason for non-acceptance of divorce by some families, however,

also includes stigma and shame arising from divorce, which is not generally accepted in the local communities. Participants stated:

"Some families wouldn't accept their daughters who are exposed to violence from their partner to go back home and divorce, because they are already married traditionally, the husband is the owner and has the right to hit her without the family interfering". (participant 9 from FGD 2)

"…when their daughter told them that her partner is abusing her, the mother said, 'that's how marriage is, there is no way out because we have already received lobola'. So, she must obey and tolerate everything the husband does, that's why". (participant 8, from FGD 6)

Recommended interventions that can be used to prevent IPV

Ending abusive relationships through the promotion of awareness about IPV and the use of support services for the victims was reported as essential by the young women participating in these discussions. They saw such strategies as key to preventing IPV and its recurrence. Participants further mentioned the need to create specific IPV counselling centres for young women to meet their needs and to give the counsellors the opportunity to screen for other potential sexual and reproductive problems which affect young women, since young women may feel stigmatised by the available services where health workers appear to be critical of their behaviour. A participant said:

"There should be more aid stations for the victims of violence, especially for young girls, this would teach young girls that violence is not acceptable…and to help them to report their other problems as young women, and to report the abuse to the authorities with no shame". (participant 3 from FGD1)

"I also think that there are counselling centres for women who suffer violence, and they should go there to get help… as young women, they should not hide this but report to authorities with no shame" (participant 5 from FGD 2).

Discussion

We conducted this research to explore the views and perceptions of young women about IPV. IPV was reported to be expected, and young women experience it early in their lives in

Maputo. The study findings provided information concerning school going young women in an urban setting in Maputo regarding their understanding of the drivers of IPV in this context. The results provide the contextual framework for improving programs to reach young women and address their needs to prevent IPV in Mozambique.

In this study, participants were not asked to disclose their personal experiences of IPV. Still, they were well aware of the problem and IPV among young women in their communities. They explained this was from their observations of their mothers' experiences, their friends sharing their experiences and, in addition witnessing IPV experienced by friends.

Their knowledge about IPV, which occurs amongst their friends, indicates an early occurrence of IPV in this setting. This is consistent with what has been reported in quantitative studies in Mozambique, confirming a high prevalence of IPV among young women, with Maputo being one of the most affected areas. In Maputo, the prevalence of IPV among women aged 15−49 years is reported to be 54.4% [13]. Therefore, these findings from our study indicate that the current IPV prevention efforts appear to be inadequate in addressing the needs of young women, nor does it appear that such efforts have been effective in reducing the young women's vulnerabilities leading to IPV. The study shows that these vulnerabilities may result from their social context and environment, such as the community where they live, which may endorse strong ideologies of male dominance and where occurrences of violence are accepted and not challenged. This may also indicate a gap among young women regarding their skills to challenge the dominant male norms and effectively prevent IPV.

It is important to mention that the young women's knowledge about IPV was mainly orientated towards physical abuse by a male partner. This finding confirms studies that have been conducted on IPV among older and young women. Most of these studies show that male partners are the main perpetrators of violence against women and that physical violence is one of the most frequently reported forms of violence, which is used to inflict pain [8, 13, 20, 25, 26, 51]. The experiences of health workers also indicate a high number of women who are presenting with wounds, bruises and scars due to IPV [27, 28]. We note, however, that women in this study mainly reported physical and sexual violence, with less emphasis on

psychological abuse. Previous studies in Mozambique reported concurrent psychological, sexual and physical abuse, with psychological abuse being the most prevalent form of abuse [13, 20, 29].

In this study, psychological abuse needed more attention in our discussion groups since this gap is likely to impact the young women's awareness and understanding of IPV and their ability to prevent this form of abuse. Since young women are at a stage where they are initiating relationships, they need to fully understand IPV, including its implicit and explicit forms and the effects on their psychological development.

Young women in this study confirmed that they learnt about IPV through their observations and the experiences shared by their peers. The advice of friends and the attitude of mothers were seen as providing guidance and a determining factor in their understanding of IPV. Still, the results of these experiences were not necessarily positive. The young women's personal experiences at home and friends' experiences appeared to shape their views and expectations about IPV. These findings mirror studies conducted by Shamu et al., 2014 and Chernyak et al., 2020 [25, 30].

The economic constraints affecting young women and their lack of autonomy to leave an abusive relationship due to this were discussed by participants as potential hindrances of IPV prevention. Since many young women in schools are not working, the opportunity to remain at school may mean that they are not financially independent and cannot leave an abusive relationship. Particularly among younger women who are at the initiation stage of their relationship, their financial dependence might reduce their likelihood of leaving a relationship despite the violence. This is consistent with findings from a previous study which included participants from universities and secondary schools in Mozambique [20], and the studies from other similar societal contexts such as South Africa [8] and Zimbabwe [44]. Thus, effective prevention programs should incorporate interventions empowering young women economically. Investments from macro socioeconomic perspectives targeting households and communities could be effective [45]. The findings of this study contribute evidence-based information which suggests that specific programs are required aimed at improving the

economic circumstances of young women in schools in order to enhance young women's autonomy to leave abusive relationships.

Another finding from this study was that alcohol consumption might result in IPV due to the reduction in inhibitions and increased propensity to violence, leading to physical and sexual abuse. Further, the alcohol consumption highlighted in the focus group discussions was associated with male controlling behavior, and any controlling actions forced on the female partner if challenged may lead to IPV. Alcohol consumption has also been reported in many studies associated with risky behaviors and IPV[25, 41, 42]. In Mozambique, alcohol consumption amongst high school learners has been previously reported as a concern and requires immediate attention. The report published by the Department of Drug Prevention in partnership with the Directorate of Education in Maputo-Mozambique, showed learners (females and males) in high schools, including two schools in the study setting, appearing in classes under the influence of alcohol and drugs[43]. It is thus crucial to tackle alcohol use among young people in and out of school to reduce risky behaviors and IPV.

The participants discussed religiosity and IPV and reported their concern that being a believing woman who lives according to her religious principles may be disadvantaged in relationships since this can lead to acceptance of IPV. They further explained that women who may be exposed to IPV might be tolerant of such abuse if they endorse the belief that males have the right to make all the decisions, and this may perpetuate violence. In settings such as Ghana and Togo, the women committed to religion were less likely to openly disclose IPV, but this was not the case amongst those not committed to any religion [46, 47]. A probable explanation for these findings is that the women who endorse religious beliefs may fear blame and shame in reporting the violence perpetrated by their partners if they are known by their society to serve God. Based on the information provided in this study, the role of religion in preventing IPV in this setting needs to be addressed through social and cultural perspectives. These would require collaboration with community members, leaders and educational sectors in addressing IPV awareness and developing targeted prevention strategies that consider how to protect individuals, despite the community's religious values. Such communities may not openly support IPV, but the culture within their religious communities may ignore the occurrence of IPV.

Findings suggest that IPV may be seen as a social construction derived from the social structure which supports gender inequality and masculinity norms. Thus, it is urgent to provide the evidence to inform interventions which need to include law enforcement that stresses human rights. Communities and social structures are required to enhance the freedom of young women and provide them with the autonomy to live their lives free from violence.

The views of young women confirm the evidence that has been produced by gender-based violence researchers over the past years[7, 26, 51, 52,53]. Participants indicated that IPV is deeply entrenched in cultural practices and decision-making processes where men make all the decisions concerning their relationship and women's sexual and reproductive health. Cultural practices such as lobola, where the families of the brides receive gifts and money, and in exchange, their daughter joins the husband's family, was reported by women as promoting violence. The rationale for this is that some families do not allow their daughters to divorce when their partners abuse them because of the stigma and the fact that they would need to return the acquired lobola[37]. Further, although it is acceptable and normal for men to have more than one partner in some societies, this is likely to promote disharmony and may lead to violence[7, 12, 15,38, 53]. Further, with the current prevalence of epidemics such as HIV and other sexually transmitted infections, the risk of multiple sexual partners can affect the health outcomes of all the women[1, 39, 40].

The FGD participants suggest the need to raise awareness about available services and also the need for specific services where young women can report IPV and other sexual and reproductive related problems. Participants expressed concern about the demand for reliable referral services for this specific population group of young women in which IPV and other sexual and reproductive concerns could be addressed. In Mozambique, as in many other African countries, the services that exist to address IPV are not specific for young women[27, 28, 48]. The opportunity for those young women in dating or in occasional relationships or those initiating relationships and experiencing IPV to seek help may be limited. Services are required where they can seek help, disclose IPV and other potential problems related to their sexual health and human rights[49]. Therefore, this study advocates new approaches and programs to meet young women's needs and enhance the reporting and prevention of IPV. These new structural programs should consider the multifaceted determinants often

associated with the cultural and structural constraints affecting this specific population group as described above. Concerted and improved awareness campaigns advertising the available services that support their communities would help young women reach the counselling centres[4,50]. The opportunity to improve young women's awareness about IPV and the use of support services can be used during promotion activities at school on sexual and reproductive health and rights and in addressing the prevention of adolescent's sexual risk behaviours. As this study has shown, it is essential to take cognizance of young women in their contextual environment to empower them with the necessary knowledge and skills to reduce their vulnerabilities.

Young women in this study see IPV as a violation of human rights. Although IPV has been seen as a private issue of concern only to relatives in Mozambique, in recent years, it has been considered a public health concern and a human rights issue. Since the United Nations declaration on violence against women, various actions have been implemented across countries[31].

In Mozambique in particular, the declaration contributed to advocacy for the law on domestic violence[32], which aims to protect the victims of gender-based violence. Since then, more than ten years have passed, and the issues of violence against women, including IPV, should be seen as a priority for the attention of the Mozambican Government to achieve a reduction and prevention of IPV. However, the gender policy and the strategies for its implementation were only approved recently in 2018 in Mozambique, and therefore, evidence regarding the results of the policy is still limited[33 34]. As the WHO states, such laws may increase conscientization that violence is unacceptable and may improve social support and disapproval of violence [35, 26]; However, despite the improvement in this regard, young women in Mozambique remain vulnerable to IPV due to multiple factors which may lead to IPV.

Strength and limitations

The findings of this study should be seen in light of the following limitations. The study focused on young women attending classes in secondary schools in Maputo city and excluded those who were not school going. Thus, the study may have potential selection bias since young women who attend schools due to their educational attainment are probably aware of

IPV and are more likely to discuss IPV aspects. In contrast, those young women who are not attending school are perhaps less informed about IPV and less likely to have similar views and perspectives about IPV. Thus, the findings of this study cannot be transferred to all young women in Maputo city but may be transferrable to other young women attending Secondary schools in a similar setting elsewhere. Participants in this study were between 15−22 years and those attending day classes. This may have limited the ability of the study to obtain the views of those working or those attending night classes. The study used focus group discussions to gather information from young women. Still, since this method lacked privacy, the confidentiality of the data could not be guaranteed. Although this had been explained to the participants, it may have limited the participants' ability to disclose their personal experiences of IPV. However, our study aimed at exploring young women's views and perspectives about IPV and the actions that should be taken to reduce IPV. The findings generated an understanding of contextual factors influencing IPV, and these provide the hypotheses that could be tested using quantitative methods in subsequent research**.**

Conclusions

The findings of this study offer insights for the development of contextual interventions to prevent IPV among young women in Maputo. This study contributes to the literature by providing qualitative data. It has identified contextual factors behind the knowledge, attitudes and perspectives on IPV in this specific group of young school attending women (15−22 years). Evidence on IPV in Mozambique is mainly reported in statistics from cross-sectional studies rather than through the exploration of young women's own views and perspectives. Nonetheless, interventions programs are not focusing on this population, as current interventions mainly address the general population of married or cohabiting women [33]. There is still a need to continue to expand the research for evidence-based information to help government and programmers to understand IPV and address priority programs in line with the SDG target in 2030 [16], to promote gender equity and reduce violence against young women. This study sheds light on significant issues to be addressed in order to enhance current interventions.

The findings call for the consideration of programmatic approaches to enforce the existing resources for preventing IPV through linking structural, economic and cultural improvements. Coordinated efforts between different stakeholders in a society aiming at addressing the male dominance norms and the social acceptance of interpersonal violence are urgently required. This should include law enforcement strategies and programs (including school programs) that stress human rights and disapproval of violence through the communities and the social structures to ensure social support for the prevention of IPV in Mozambique.

Data availability

The data underlying this article cannot be shared publicly due to the privacy of the individuals that participated in the study. The data will be shared at reasonable request to the corresponding author.

Ethics Statement

This study was reviewed and approved by the Humanities and Social Sciences Ethical Committee (HSREC) from University of KwaZulu Natal, Durban, South Africa ref: HSS/2005/018D and by the National Health Bioethics Committee of Mozambique (CNBS) ref: 360/CNBS/19. Subjects gave written consent to participate and written confirmation that there was an understanding of the objectives of the study and that they could decline to join at any time.

Authors contributions

MSBM, MT, and NK were involved in revising the manuscript critically for important intellectual content, gave final approval of the version to be published, agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved and made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data.

Funding

This work is part of a more extensive ongoing study that has been conducted by MSBM with the financial support of ISCISA, NICHE, and the UKZN. ISCISA NICHE and UKZN had

no role in designing this study, preparation of the manuscript, and decision to have it published. Furthermore, the views, opinions, assumptions, or any other information presented in this manuscript are solely those of the authors.

Conflict of Interest Statement

The authors declare that they have no financial interest that may have inappropriately influenced them in writing this article.

Acknowledgements

The authors acknowledge the Instituto Superior de Ciências de Saúde (ISCISA), Maputo-Mozambique, the Netherland Initiative for Capacity development in High Education (NICHE) and the University of KwaZulu-Natal (UKZN), Durban- South Africa, for the provision of resources toward this article. The authors would like to thank the participants for their participation and discussions.

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CHAPTER SEVEN

PUBLICATION

Paper 4: Risk factors associated with high prevalence of intimate partner violence amongst school-going young women (aged 15–24years) in Maputo, Mozambique

Authors: Maria Suzana Maguele, Boikhutso Tlou, Myra Taylor, Nelisiwe Khuzwayo.

Status: Published

Date Published: December 9, 2020

Journal: Plos One; Maguele MS, Tlou B, Taylor M, Khuzwayo N (2020) Risk factors associated with high prevalence of intimate partner violence amongst school-going young women (aged 15–24years) in Maputo, Mozambique. PLoS ONE 15(12): e0243304. https://doi.org/10.1371/journal.pone.0243304

Introduction

The findings in Paper 3 suggested occurrence of IPV among young women in the communities. Four main themes emerged from the analysis. The first theme described the knowledge of young women about IPV through witnessing friends physically abused by their partners, friends sharing personal experiences of IPV and the accepting attitudes of their mothers toward IPV. The second theme explained the meanings that young women give to the occurrence of IPV. IPV was viewed by many participating women as an expression of male chauvinism and a violation of human rights, with alcohol use a contributing factor. The third theme explored the reasons for their acceptance of IPV from the perspectives of the young women. Complex individual, community and societal factors promoted acceptance of IPV, including the low economic status of women, the influence of their friends who accepted IPV, their religious beliefs and the social acceptance of violence, and the fourth theme described the recommendations advocated by the young women to prevent IPV. Their knowledge about IPV which occurs amongst their friends, indicates an early occurrence of IPV in this setting, and therefore a concern. Although, these results indicate the urgent need for contextual action, further information is required about the extent of the problem and to suggest specific

improvements to the current interventions. Despite the WHO recommendation that young people be included in prevention programs early, in Mozambique this recommendation has yet to be implemented effectively. The delay could be due to a lack of understanding of the contextual risk factors and evidence of their magnitude and this is required to persuade policymakers to take action. We therefore conducted a descriptive and analytical study to determine the prevalence and the risk factors associated with IPV among school going young women in Maputo, to provide the statistics for the contextual information required for tailor made interventions aimed at preventing IPV among young women.

Doctoral student's contribution

I conceptualized the study under the guidance of the supervisors, Professor Myra Taylor and Dr Nelisiwe Khuzwayo. I did the data collection and Mr Boikhutso Tlou assisted with the data analysis. I drafted the manuscript and the Supervisors critically reviewed it. All authors read and approved the final manuscript.

PLOS ONE

RESEARCH ARTICLE

Risk factors associated with high prevalence of intimate partner violence amongst school-going young women (aged 15–24years) in Maputo, Mozambique

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Citation: Maguele MS, Tlou B, Taylor M, Khuzwayo N (2020) Risk factors associated with high prevalence of intimate partner violence amongst school-going young women (aged 15–24years) in Maputo, Mozambique. PLoS ONE 15(12): e0243304. https://doi.org/10.1371/journal.pone.0243304

Editor: Geilson Lima Santana, University of Sao Paulo Medical School, BRAZIL

Received: April 30, 2020

Accepted: November 18, 2020

Published: December 9, 2020

Data Availability Statement: All relevant data are within the paper and its Supporting Information files.

Funding: The Instituto Superior de Ciências de Saúde, the Netherlands Initiative for Capacity Development in Higher Education and the University of KwaZulu-Natal, College of Health Science has funded this research as part of a Ph.D. study. These three institutions had no role in the design of this study, the preparation of the

Abstract

Background

In many countries, there is evidence that intimate partner violence is prevalent among young women. This study aimed to determine the prevalence and the factors associated with intimate partner violence in young women (aged 15–24 years) attending secondary schools in Maputo, Mozambique.

Method

Using a probability proportional sampling strategy, 431 participants were recruited, and the data were collected using a self-administered questionnaire. Binary and multivariate logistic regression analyses were performed to assess the association between IPV and sociodemographic and sociocultural factors. Odds ratio (OR) and 95% confidence intervals (CI) are reported.

Results

Of the 413 participants, 248 (60%) (95% CI: 55.15–64.61) had experienced at least one form of IPV in their lifetime. Then, of the 293 participants who had a partner in the previous 12 months prior to the data collection, 186 (63.4%) (95% CI: 57.68–69.00) reported IPV in the 12 months prior to data collection. The psychological violence was the predominant type of violence, lifetime prevalence 230 (55.7%), and over the previous 12 months 164 (55.9%). The risk of IPV was associated with young women lacking religious commitment (AOR, 1.596, 95% CI: 1.009–2.525, p = 0.046) and if the head of the young women's household was unemployed (AOR, 1.642 95% CI: 1.044–2.584, p = 0.032). In the bivariate analysis the odds of being abused remained lower among the younger teenage women (OR, 0.458 95% CI: 0.237–0.888, p = 0.021), and higher, among young women if the partner was employed (OR, 2.247 95% CI: 1.187–4.256, p = 0.013) and among the young women believing that males are superior to females (OR, 2.298 95% CI:1.014–5.210. p = 0.046).

manuscript and the decision to have it published. Furthermore, the views, opinions, assumptions or any other information presented in this manuscript are solely those of the authors.

Competing interests: The authors have declared that no competing interests exist.

Conclusion

These findings reveal a high prevalence of IPV among young women. Comprehensive programs should incorporate socioeconomic empowerment strategies to increase women's autonomy. There is a need to address religious beliefs through cultural perspectives, to improve social interactions that promote violence free relationships, gender egalitarian norms, and physical and emotional wellbeing for young women.

Background

The World Health Organization (WHO) estimates that globally one in three women experience violence from their partners and, in the region of Sub-Saharan Africa (SSA) the statistics point to 36.6% [1]. Intimate partner violence (IPV) in SSA among ever-partnered women aged 20–24 years and among women aged 15–19 years is estimated to be 31.6% and 29.4%, respectively [1].

Globally the number of young women is increasing, with 12% of the world's population being females aged 15–24 years [2]. Many of these young women live in developing countries, where they are affected by inequalities, such as their low level of education and high rate of unemployment [2]. Such factors affect their autonomy in making decisions about their lives, and in allowing them financial independence. This may lead them to potentially vulnerable relationships that put them at risk of violence such as IPV.

The Sustainable Development Goal 5 (SDG) emphasizes the need to address gender inequalities and the target date to achieve this is 2030. This requires that actions be taken, and programs developed over the next decade [3].

In addition to the social inequalities affecting young women, as a result of their youth there may be specific risk factors, and in particular contextual risk factors that affect young women, that could influence their vulnerability to partner violence.

Therefore, investigating such risk factors for IPV and obtaining evidence of their magnitude among young women is important to inform policymakers and programmers, in order to develop appropriately targeted interventions.

While numerous factors influencing IPV against women have been identified by social scientists, most of the studies are focusing on older women [4]. The factors most reported about women in general include individual factors such as their HIV-positive status, level of education, economic status, having witnessed violence during childhood and partner's alcohol abuse [5–7]. Patriarchal societies have also been reported as promoting IPV against women [8–10]. For instance, in many African societies male figures occupy senior positions in their families and communities. Women are socialized to accept the seniority of their male partners and are required to comply. For instance, although according to custom a male can have more than one wife, this may expose the female partners to poor physical and emotional health [11].

The gender roles and negative community norms that influence IPV require communities to reflect and develop improved strategies for promoting norms that will be beneficial to both sexes so that IPV can be eliminated.

The continuing practice of IPV in families and communities affects the socialization of young people [12–14]. In addition and of major concern, is that young people start dating early in their lives [4, 15]. However, in most SSA countries there are no structured interventions to prepare them before they start dating, and they thus tend to imitate practices to which they have been exposed, such as IPV [4, 16–18].

Although there is increased awareness about the problem of IPV since the 2013 WHO report, providing solutions to address the problem remains a concern. According to the WHO (2020), research investigating factors underpinning IPV among young women remains of particular importance since the prevalence around the world is still escalating [19]. Coll et al. (2020) also highlight in their study the many countries where IPV is increasing, although there are exceptions in some smaller countries [20]. There is a need to develop appropriately targeted interventions, depending on the age and circumstances of the women.

Mozambique is one of the countries with a high prevalence of IPV. The most recent data report that the lifetime prevalence of IPV among women aged 15–24 years ranges between 36% and 47.8% [21]. Further, amongst young women in Mozambique the factors that were reported to influence IPV included sexual coercion, early marriage, early dating relationships, alcohol abuse and economic constraints [21–23]. Information is urgently required to suggest specific improvements to address the current dearth of intervention programs that address the needs of young women, and to provide evidence to encourage policymakers to act, in order to work towards achieving SDG 5.

Young women are more likely to provide valid responses if the questionnaire is confidential and anonymous [24]. In Mozambique prior studies were conducted more than seven years ago. To obtain more up to date and accurate information in order to promote change and reduce the occurrence of IPV, this study aimed to determine the prevalence and the risk factors for IPV in young women aged 15–24 years attending secondary schools in Maputo, Mozambique in 2019.

Material and methods

Study area and setting

The study was conducted in three secondary schools in KaMpfumu District Municipality, Maputo. These schools comprise the majority of the secondary schools in Maputo, enrolling students from grades 8 to 12. The KaMpfumu District Municipality is the most urban area of Maputo, covering an area of 12 square kilometres, and the total population is 80 550, of which 42 575 are females [25]. Youth in the age group 14–24 years constitute about 49% of the population. KaMpfumu District has the lowest level of poverty among the seven city districts, estimated at 28%. This metropolitan area is populated by people from different backgrounds, economic class, cultures and perspectives concerning health-seeking behavior [25]. The prevalence of IPV among school-going young women aged 15–24 years in Maputo is unknown; however, the prevalence among the general population aged 15–49 years is estimated to be 54.4% [21].

Study design and population

This was a cross-sectional study following focus group discussions that explored the factors associated with IPV among young women in Maputo. A review of the literature indicated a lack of information about contextual factors associated with IPV among young women. In total six focus groups were held with young women (15–24 years) at schools to explore their perceptions of the risk factors associated with IPV. These young women did not participate further in the study.

In Mozambique, although education is free through 12 years of age, the female literacy rate is 28% [26]. The study population was young women 15–24 years and women attending classes in each of the selected schools during August and November 2019, aged between 15–24 years, were included in the study. Women aged 15–24 years are at increased risk of adverse health and reproductive health outcomes [5] and since young women in Mozambique often

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start school when they are older, 15–24 year old women are to be found in secondary schools [26, 27]. Also, since schools are often the setting where young women receive education and health promotion programs, it is feasible that comprehensive programs can be provided aimed at empowering young women with the knowledge and skills to reduce their vulnerabilities. Such interventions can contribute to changing behaviors through collaboration with the educational sector and consideration of the contextual environment when targeting youth [28].

Study sample

The sample size calculation was based on the population-proportional size sample, using a 95% confidence interval and a 5% degree of precision. We expected 50% prevalence, and therefore added 10% to the sample for invalid responses [29]. The probability proportional random sampling strategy was employed to select the 450 participants from all the classes in the schools, based on the total number of students per academic class, per age group. The random selection provided an equal chance for all the students to be selected so that the findings could be generalized to similar populations. All the participants who mentioned that they had never been in a relationship (n = 19) were subsequently excluded from the study.

Data collection

Pilot. The questionnaire was piloted in a school with a similar setting, but not included in the study, amongst 42 young women (nearly 10%), to ensure clarity of the questions and consistency in the methods of questioning and the data collection procedure. After the pilot, some issues relating to the demographic information were re-formulated for the school-going population in an urban setting in Maputo.

Instruments. Prior to the survey an exploratory study using focus group discussions was conducted and themes were generated to explain the IPV experienced by young women in Maputo city. The questionnaire for the survey was adapted informed by the themes and based on the WHO Multi-country surveys of violence against women instruments (Garcia-Moreno, 2005). We also based our questions on the socioecological model (Bronfenbrenner, 1998) [30]. The themes that emerged from the focus group discussions were integrated into the model for variables and included individual factors (Age of women, age of partner, young women's relationship status, young women's employment status; HOH education level, HOH employment status, partner employment status), community factors (religiosity) and societal factors (perceptions of gender roles).

The questionnaire used in this study to estimate the IPV and associated factors was adapted from the WHO Multi-country Survey of Women's Health and Domestic Violence against Women (Garcia-Moreno, 2005). The WHO Multi-country tools are recommended since they cover issues of IPV and their validity and reliability have been confirmed [31]. The questionnaire's validity in the Portuguese language was confirmed in the study done in Brazil in two different social contexts (urban and rural). The results indicated the adequacy of the instrument in estimating the occurrence of IPV and the associated factors. The study reported a Cronbach alpha coefficient of 0.88. Thus, the instrument has been shown to be reliable, consistent and adequate to be used in other similar studies accessing IPV, in different contexts such as this study [32].

The questionnaire was translated from English (S1 Appendix) to Portuguese (S2 Appendix) and back translated into English by a second translator to ensure consistency. The selection of the questions was designed to address the sociocultural context of the young women attending secondary schools in Maputo, based on the information obtained from the focus groups and the available literature.

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Our study was done in an urban setting and the instrument enabled us to estimate the different types of violence (physical, sexual and psychological). The IPV was measured both across the lifetime and in the 12 months prior to conduct the survey.

Dependent variables. The dependent variables comprised acts of physical, sexual and psychological violence, and the questions were adapted from the WHO Multi-country Survey of Women's Health and Domestic Violence against Women (Garcia-Moreno, 2005), using the subscales of the Abusive Behavior Inventory of physical violence [33], psychological violence [34] and sexual violence [35]. Physical, sexual or psychological violence was assessed by questioning if, since the age of 15 the young woman had ever experienced one of the acts from a current or past partner. Experience of physical, sexual or psychological violence was considered confirmed if the response was "yes" to at least one of the defined criteria questions.

Physical violence (8 questions). For example: "Has he or any other partner ever slapped you or thrown something at you which could hurt you?"

Sexual violence (10 questions). For example: "Has he or any other partner ever physically forced you to have sexual intercourse?"

Psychological abuse (13 questions). For example:" Has he or any other partner called you insulting names?".

The questions presented to participants to assess the occurrence of each type of violence are detailed in the questionnaire (S1 Appendix).

The lifetime prevalence of IPV was defined as the proportion of women who have or ever had an intimate partner and reported violence from a partner at any time in their life since the age of 15 years.

The current prevalence or 12 months prevalence of IPV was defined as the proportion of women who currently have or ever had an intimate partner in the previous 12 months before the survey and reported violence in the previous 12 months.

An intimate partner was defined as any male partner with whom the young women have or ever had a romantic relationship that included sexual activities, either spouse/husband, boyfriend/dating partner, or ongoing sexual partner/occasional partner. The definition was based on the sociocultural context of an urban setting in Maputo. After accessing the meanings young women attribute to intimate relationships, during the pilot. Therefore, we contextualized the definition to address the specific group during the survey.

Independent variables. This study is part of a larger study undertaken to assess the prevalence and risk factors for IPV among young women in Maputo city. Prior to the survey an exploratory study using focus group discussions was conducted and themes were generated to explain the IPV experienced by young women in Maputo city. Therefore, the questionnaire, based on the WHO Multi-country surveys of violence against women was informed by the contextual themes and the literature concerning IPV against women. For example, the focus group discussed themes of religiosity and IPV. Therefore, we included the religiosity as a contextual variable to investigate how religion might shape young women's perspectives, beliefs and the influence on IPV. The variables were also informed by the available literature to explain the risk factors for IPV in different sociocultural contexts. In settings such as Mozambique the society is dictated to by social norms which give privilege to male dominance [21, 23, 36]. Thus, since contextual sociocultural factors may explain the occurrence of IPV, we included sociocultural variables. We also included questions from the socioecological model which established that the risk factors for IPV emerge from different constructions within people's interactions. These included individual, relationship, community and societal factors (Bronfenbrenner, 1998). The independent variables were divided into two sections. Section one comprised socio-demographic characteristics measured as categorical variables and section two investigated the sociocultural risk factors for IPV considering agreement or

disagreement with statements of male superiority and the statements of acceptance of IPV. These were measured on a 4-point Likert scale from strongly agree, agree, disagree and strongly disagree [37].

Section one of the questionnaire comprised questions about:

Socio-demographic factors: Age, divided into two categories (15–19, 20–24 years); Employment status of respondent; Relationship status of respondent; Commitment to religion: Defined as the degree to which a participant adheres to his or her religious values, beliefs, and practices and uses them in daily living. These were measured as yes/no responses.

Household factors: With whom the participant lives; by whom the participant was raised; Educational level of the Head of Household (HOH); Employment status of the HOH.

Partner background: Age differences between the young women and partner; Alcohol consumption by partner; Employment status of the partner.

Section two comprised sociocultural variables measuring risk factors, and examples of the questions are provided:

Perceptions of gender roles (8 questions): For example: "Do you believe that a man has a superior position within a society than women?".

Tolerance of violence (8 questions). For example: "There are times when violence by men to women is okay".

Ethics

This study was approved by the Humanities Social Sciences Research Ethics Committee of UKZN (HSSREC), ref: HSS/2005/018D, and the National Health Bioethics Committee of Mozambique (CNBS), ref: 360/CNBS/19. Permission was obtained from the National Directorate of Education in Maputo and the directorates of the selected schools. Consent forms and assent forms were explained and distributed to all participants before the study. All participants provided written informed consent voluntarily. Participants under 18 years of age provided assent and the consent from their parents or guardians. After they returned signed consent forms, they were eligible to participate in the study. No monetary reimbursement was given to them for their participation. Anonymity and confidentiality were ensured, and the participants' names were not written on any questionnaires. Privacy was maintained by keeping the participants separated from each other during the completion of the self-administered questionnaire. They were told that their participation was voluntary and that they had the right to terminate it and they were assured that they would not be affected in any way if they decided to do this. There was minimal risk that the study had the potential to bring back negative memories, but participants were told to inform the researchers if this occurred, and they were assured of the availability of referral services. Participants benefited from the information about IPV and how to prevent IPV that was provided after the survey. The researcher made available contacts for reference services for assistance in case participants needed help if they experience violence. Those participants who contacted the researcher after the survey who reported experiencing IPV, were provided with the names and contact details of the services providing assistance to women suffering from gender-based violence and IPV.

Data analysis

The Hosmer and Lemeshow test of the goodness of fit suggested the model was a good fit to the data as $p = 0.396$ (> 0.05). The chi-square statistic on which it is based is very dependent on sample size, so the value cannot be interpreted in isolation from the sample size. However, we had a powered sample and our data also met the one in ten rules of thumb of ten outcome events per predictor variable in the logistic regression.

Data were analyzed using SPSS version 25.0 computer software after assessing its completeness. Proportions were used to estimate the lifetime and current or 12 months prevalence of IPV among young women. For lifetime IPV the denominator included all women who currently have or ever had an intimate partner and reported ever experiencing IPV at any time in their life. For 12 months IPV the denominator included all women who currently have or ever had an intimate partner in the 12 months prior to survey and reported experiencing IPV in the 12 months prior to survey [31, 33].

Logistic regression was used to identify risk factors associated with IPV, and odds ratios (OR) and 95% confidence intervals (CI) are reported. After conducting the bivariate analysis of IPV and the potential risk factors, significant risk factors, were then included in the multivariable logistic regression. A p value <0.05 was deemed statistically significant.

Results

Sample description

Overall, 450 young women were enrolled in the study, but only 431 were included in the analysis. The age of participants ranged between 15 and 24 years, where the mean age was 18 (SD 1.514). Most of them 368 (85.4%), were in the 15–19 age group. Of the respondents, 226 (52.4%) had completed grade 10, 399 (98%) were unemployed, 259 (61.7.%) were committed to religion, and 286 (66.4%) were in a dating relationship at the time of data collection. Over half of the young women's HOHs 238 (56%) were employed. Of the young women's partners, 311 (72.2%) were not alcohol users, 366 (85.3%) were unemployed, and 194 (45.8%) were younger than or the same age as the young women. The socio-demographic characteristics of the study participants are presented in Table 1.

Prevalence of IPV

Lifetime prevalence of IPV. Of the 413 young women who provided information about their experiences of IPV, 248 (60%) (95% CI: 55.15–64.61) had experienced at least one form of IPV in their lifetime. More than half of the young women, 230 (55.7%), had experienced at least one act of psychological violence, 120 (29.1%) had experienced at least one act of sexual violence, and 93 (22.5%) had experienced at least one act of physical violence. Of the study participants 45 (10.9%) had experienced all three forms of violence, with co-occurrence of two forms of violence reported by 55 (13.3%) for psychological and sexual violence, 32 (7.4%) for psychological and physical violence and 5 (1.2%) for sexual and physical violence. There were 361 women in the 15–19 years age category and 209 of them had experienced IPV constituting a proportion of 57.9%, whereas of the 52 women in the 20–24 age group, 39 of them experienced IPV constituting a proportion of 75.0% of that age group. In general, the overall IPV increased with increasing age, with psychological violence predominating in both age categories.

12 months prevalence of IPV. Of the 293 young women who had a partner in the previous 12 months, 186 (63.4%) (95% CI: 57.68–69.00) reported IPV in the 12 months prior to the data collection, with psychological violence predominant, reported by 164 (55.9%) respondents (Table 2). Physical violence was reported by 55 (18.7%) respondents, and the prevalence of sexual violence was higher at 71 (24.2%).

As expected, the overall 12 months prevalence of IPV decreased with increasing age. In general, the younger women had a higher prevalence of current IPV as compared with the older age category. There were 238 women in the 15–19 years age category and 155 (65%) of them had experienced IPV whereas of the 55 women in the 20–24 age group, 31 (56.4%) of them experienced IPV. However, some variations in the pattern suggest that although the older

Table 1. Socio-demographic characteristics of young women.

Age categories (years)	Frequency	Percent (%)
Mean: 18 (1.514)	**n = 431**	
15–19	368	85.4
20–24	63	14.6
Education level (n = 431)		
Grade 10	226	52.4
Grade 11	205	47.6
Religiosity (n = 420)		
Committed to religion	259	61.7
Not committed to religion	161	38.4
Status of employment (n = 407)		
Employed	8	2
Unemployed	399	98
Status of relationship (n = 431)		
Currently married	7	1.6
Currently in relationship/dating	286	66.4
Currently not in a relationship but have had previously	138	32
Head of household status of employment (n = 425)		
Employed	238	56
Unemployed	187	44
Partner alcohol use (n = 431)		
Partner alcohol user	120	27.8
Partner not alcohol user	311	72.2
Partner status of employment (n = 429)		
Employed	63	14.7
Unemployed	366	85.3
Partner age difference (n = 424)		
Less than ten years older	188	44.3
More than ten years older	16	3.8
Younger/same age	194	45.8
Do not know	26	6.1

https://doi.org/10.1371/journal.pone.0243304.t001

women are more protected from psychological violence, they are likely to be more at risk of physical and sexual violence as compared to younger women.

The lifetime and previous 12 months prevalence of IPV are presented in Table 2.

Factors associated with IPV

In the bivariate analysis the odds of experiencing IPV were significantly lower among younger women, (OR, 0.458, 95% CI: 0.237–0.888, p = 0.021), compared to those in the older age categories. The odds ratio of experiencing IPV were significantly higher among young women who were not committed to religion (OR, 1.591, 95% CI: 1.048–2.415, p = 0.029), and young women whose HOH was unemployed (OR, 1.562, 95% CI: 1.021–2.392, p = 0.04). The risk of IPV doubled for the young women whose partners were employed (OR, 2.247, 95% CI:1.187–4.256, p = 0.013). For those whose partners were more than ten years older, the risk of IPV appeared to be more than fourfold higher (OR, 4.5283, 95% CI: 0.986–20.805, p = 0.052). A strong trend associated with IPV was also seen for young women who agreed with one statement of male superiority (OR, 2.298, 95% CI: 1.014–5.210, p = 0.046). The

Table 2. Lifetime and previous 12 months prevalence of physical, sexual and psychological violence by age categories.

Lifetime IPV	Prevalence		Age categories (n = 413)	
Overall	Frequency	Percent	15–19 (n = 361)	20–24 (n = 52)
	248	60	209 (57.9%)	39 (75%)
Physical	93	22.5	72 (20%)	21 (40.4%)
Sexual	120	29.1%	91 (25%)	29 (55.8%)
Psychological	230	55.7%	191 (53%)	39 (75%)
12 months IPV	**Prevalence**		**Age categories (n = 293)**	
Overall IPV	Frequency	Percent	15–19 (n = 238)	20–24 (n = 55)
	186	63.5	155 (65%)	31 (56.4%)
Physical	55	18.7	44 (18.5%)	11 (20%)
Sexual	71	24.2	53 (22.3%)	18 (32.7%)
Psychological	164	55.9	137 (57.6%)	27 (49.1%)

https://doi.org/10.1371/journal.pone.0243304.t002

other sociocultural variables were not found to be significantly associated with young women's experience of IPV.

The multivariable analysis confirmed the association between IPV and the young women's lack commitment with religion (AOR, 1.596, 95% CI: 1.009–2.525, p = 0.046) and with young women's HOH unemployment status (AOR, 1.642, 95% CI: 1.044–2.584, p = 0.032). There were also trends that the risk of IPV increased if the young women's partner was more than ten years older, (AOR, 3.183, 95% CI: 0.661–15.341, p = 0.149) and if he was employed (AOR, 1.675, 95% CI: 1.044–2.584, p = 0.155). Similar trends indicated lower odds of IPV among the younger women (AOR, 0.750, 95% CI: 0.365–1.541, p = 0.434) as compared to the older women and also lower among young women who agreed with one statement of male superiority, (AOR, 0.894, 95% CI: 0.524–1.525, p = 0.682). The logistic regression analysis results are presented in Table 3.

Table 3. Logistic regression analysis of demographic and sociocultural variables: IPV dependent variable: Ever-experienced IPV.

		Bivariate			Multivariable		
Predictor variables	**Categories of Predictor variables**	**OR**	**95% CI**	**P-value**	**AOR**	**95% CI**	**P-value**
Age of women	15–19	0.458	0.237–0.888	0.021	0.750	0.365–1.541	0.434
	20–24	Ref			Ref		
Religion commitment	No	1.591	1.048–2.415	0.029	1.596	1.009–2.525	0.046*
	Yes	Ref			Ref		
Employment status of the head of household	Unemployed	1.562	1.021–2.392	0.04	1.642	1.044–2.584	0.032*
	Employed	Ref			Ref		
Employment status of partner	Yes	2.247	1.187–4.256	0.013	1.675	1.044–2.584	0.155
	Do not know	0.179	0.037–0.854	0.031	0.302	0.031–2.908	0.300
	No	Ref			Ref		
Age difference of the partner	Less than ten years older	1.438	0.944–2.190	0.091	1.384	0.868–2.207	0.172
	More than ten years older	4.528	0.986 –20.805	0.052	3.183	0.661– 15.341	0.149
	Do not know	0.278	0.111–0.693	0.006	0.360	0.114–1.139	0.082
	Younger or same age	Ref			Ref		
Do you believe that a man has a superior position within a society than women	Agree	2.298	1.014–5.210	0.046	0.894	0.524–1.525	0.682
	Disagree	Ref					

* = Statistically significant in multivariable logistic regression (AOR).

https://doi.org/10.1371/journal.pone.0243304.t003

Discussion

The results of this study provide new information about young women attending Maputo secondary schools regarding the prevalence of IPV and the factors placing them at risk. Mozambique, as with many Sub-Saharan African countries has had a difficult history and experienced much violence in the 20th century. The high prevalence of IPV reported by these young women, more than half of whom had experienced IPV, emphasizes the need for targeted interventions. The factors associated with IPV emphasize the importance of changing social norms away from the acceptance of IPV and perceptions of male superiority, and to develop a more gender equitable society that values the contribution of young women, the target of SDG 5. Since women constitute 51.4% of the Mozambique population [38], it is critical that the state provides economic opportunities that allow young women to be independent and to fulfil their potential. Targeting young women who are attending school would appear to be a feasible initial strategy.

Previous studies undertaken in Mozambique include the National Demographic Survey which had a section on domestic violence among the general population [21], studies undertaken on clinical samples in healthcare centres [39, 40] and a study targeting universities and secondary school students, between the ages of 15 and 45 years. This latter study measured 12 months' prevalence of IPV and lifetime prevalence of non-partner violence, that is, violence from other sources [22].

It may be difficult to compare the prevalence data on IPV because previous studies used different methods. For example, the national and clinical surveys considered women at risk as only ever married/cohabiting women of reproductive age. The study among university students considered currently partnered women. In our study we considered all women who ever had an intimate partner from the age of 15 (Garcia-Moreno, 2005) and we included all those who currently have or those currently not having, but who ever had an intimate partner.

These previous studies did not provide clarity regarding the prevalence and the factors underpinning IPV in the specific group of secondary school-going young women (aged 15–24) years in Maputo. As the capital city of Mozambique, Maputo draws migrants from many other parts of the country and is an appropriate place to initiate targeted programs in schools to reduce IPV, in order to work towards SDG 5 against gender violence.

Prevalence of IPV among young women

In our study, the lifetime prevalence of IPV of 60% among young women was higher than that reported in previous studies in Mozambique, which ranged from 36% to 47.8% [21]. It was however similar to that reported in studies across SSA countries among women aged 15 to 24, where the lifetime prevalence of IPV ranged from 19% to 66% [41]. The prevalence in our study is slightly higher than the findings from a recent study that explored the trends in prevalence and risk factors associated with IPV among Zimbabwean women of reproductive age, where the prevalence among women aged 15–24 years ranged between 43% and 48%. The prevalence is also higher than findings from the United States of America (USA), where the prevalence ranged from 8% to 51.2% [42–45].

The 12 months' prevalence of IPV reported in our study of 63.5% is similar to a previous study in Mozambique among universities and secondary school women, where the 12 months prevalence was reported at 63.2% [22]. The 12 month prevalence reported in our study is higher than that reported in studies from SSA and elsewhere, which ranged from 7% to 57%, where for example in Serbia, IPV prevalence was 7%, and in Ethiopia, where the reported prevalence was 57% [41]. Similarly, the prevalence reported in our study is higher than reports in a recent study conducted in Low and Middle-Income Countries, where the range was between

34.4% to 46% [20]. Comparisons between our study and other studies are challenging due to the different measures used for current IPV and the different time periods. In South Africa, a study involving 2 115 grade 8 learners, which measured IPV prevalence over 12 months using an interview administered questionnaire, reported the prevalence at 30.9% [46]. Similarly, in a study from Tanzania among a sample of 226 young men and women, amongst the young women aged 15–30 years the overall prevalence of IPV measured in the previous 12 months was 35.8% [13]. In another study conducted in South Africa, the data regarding the prevalence of IPV over three months, were collected through self-completed interviews among a sample of grade 8 students, and the prevalence was 39.1% [47].

The study involving ten countries from the WHO Multi-country Study on Women's Health and Domestic Violence against Women, used face to face interviews as the method of collecting data in urban and rural sites [41], and under reporting of IPV was possible due to this method of data collection. In contrast, the use of self-administered questionnaires completed in an environment that provided privacy using self-reports and ensuring confidentiality and anonymity in our study, may have contributed to the participants feeling able to disclose their experiences of IPV. Therefore, the high prevalence found may be associated with the comprehensive questionnaire, training, and robust method used in collecting the data for this study.

In our study, psychological violence was the most reported form of IPV, with a prevalence of 55.7% for lifetime IPV and the prevalence of 55.9% for 12 months prevalence. Our findings are in concordance with other studies which assessed the occurrence of the three forms of IPV [21, 22]. In studies from SSA and elsewhere including the Zimbabwean study [13, 20, 41, 48] and from USA settings [44, 45, 49], psychological violence was reported as the most prevalent form of IPV. This was also found in the study conducted among grade 8 learners in an urban area of South Africa, where psychological violence was the most reported finding [46]. In contrast, another study's findings from South Africa among adolescent learners revealed that the participants experienced more physical than psychological violence [47]. The difference in the form of IPV found in a study conducted in South Africa was deemed to be the result of the attitudes of the young women disagreeing with the ideologies of male dominance, which reduced the women's risk of being emotionally abused. However, the authors' findings suggested that these attitudes of disagreement might increase the risk of physical violence, since this could possibly increase their relationship conflicts. Therefore, for those partners who use physical force to solve problems, this might be a reason to increase the use of physical violence [46, 47].

In this study the lifetime prevalence increased with increasing age and this was consistent with findings from the National Demographic and Health Survey in 2011 in Mozambique. The lower prevalence was reported among the younger age category 15–19 years (36.7%) and the higher prevalence among the older age categories 20–24 (47.8%) [21]. This was similar in a study done in SSA and elsewhere [41] and in a Zimbabwean Study [48]. However, as expected, the current prevalence of IPV decreased with increasing age. In general, the women in the youngest age category had higher current IPV prevalence as compared to the older age category. This may suggest that violence occurs early when young women enter or initiate relationship. Similar trends were observed in previous studies investigating 12 months' IPV and the youngest age women reported more IPV as compared to the older ages above 24 years [22]. This is also consistent with findings from a study conducted in Low-Middle-Income countries, including countries such as Rwanda, Namibia and Senegal [20], and in the study from SSA and elsewhere [41] where the higher prevalence of current IPV was observed among adolescents and younger adults of 15–24 years. The Spanish Macro surveys study of ever-partnered women reported higher prevalence of current IPV in women between 16–29 years [50]. However, some variations in some settings were reported. For example, in Burkina Faso, Kenya, and Ethiopia and also in some settings in Europe and Central Asia, the current IPV

prevalence was skewed among older ages as compared to younger groups between 15–24 years [20, 41]. The findings from South African studies, suggest that the young women's inexperience about relationships may limit their ability to use nonviolent methods when in conflict and to prevent violence [46, 47].

Possible explanations of the varying IPV prevalence may however be due to the different sample sizes, and the age categories. Our study recruited only school-going women between the ages of 15 and 24, whereas other studies recruited women between the ages of 15 and 49.

Factors associated with lifetime IPV

The significant factors associated with IPV are reported here in terms of the Socioecological model (Bronfenbrenner, 1998) and include individual factors (age of women, age of partner, HOH financial status, partner financial status), community factors (religiosity) and societal factors (beliefs about male superiority).

Individual factors. *Age of young women*. Our study revealed that in the bivariate analysis, the odds of being abused were lower among younger women (15–19), (OR, 0.458, 95% CI: 0.237–0.888, p = 0.021), as compared to those older (20–24) years. These findings were consistent with previous studies which reported increasing odds of IPV with increasing age among groups of young women in studies from SSA and elsewhere, and in the recent study conducted in Zimbabwe to assess the trends in IPV prevalence among ever-partnered women [21, 41, 48].

These results suggest that women in their early twenties may be more time exposed to relationship conflicts since they may be married or in committed relationships. They are perhaps more likely to face relationship conflicts and therefore to tolerate IPV and to remain in a relationship with violence, while the younger women are probably at the initiation stage of their relationships, and are therefore less time exposed to relationships and conflicting relationships, and may therefore be less likely to be committed to staying in such a relationship when there are conflicts.

Our multivariable analysis did not confirm the results of the bivariate analysis, but the high prevalence of IPV that was reported by the young women emphasizes the need for specific intervention strategies to address potential risk factors and to prevent the occurrence of IPV early in young women's lives. For example, in Mozambique, a previous study among women aged 15–49 years attending schools and universities, revealed that adolescent and young women were more vulnerable to violence compared to women above the age of 24. The study's findings also reported a positive association between their young age, their single status, their habit of going out to parties and their alcohol consumption, with increased risk of IPV [22]. In the context of South African and USA settings for example, the findings suggested that the young age of women reduced their ability to deal with the complexities and the dynamics of relationships, therefore increasing their risk for IPV [43, 45–47, 51]. In a study which explored the trends in prevalence and risk factors associated with IPV among Zimbabwean women of reproductive age (15–49 years), the older women above 40 years, were less likely to experience sexual and physical IPV compared to the younger women between 15–24 years [48]. This suggests that although the older women are more time exposed to relationships and may have experienced violence in the initial stages of their relationships, their experience regarding relationships may increase their ability to manage a more stable relationship and also to use more protective methods when in a conflicting relationship.

The likely reasons for the differences in the different studies' results concerning the age of the women experiencing IPV, may be due to the selection process for the study samples and the comparisons between different age categories. Our study recruited only school-going

women between the ages of 15 and 24 years. In Mozambique, a developing country, children often enter school when they are older than is typical in other countries and continue to attend school above the age of 20. Therefore, amongst these young women attending school to improve their educational attainment, their young age and their single status suggest that they may be less exposed to conflicting relationships, or that they can challenge and not tolerate conflict in relationships.

Further, the older age category in the study is less represented in the sample size and in this setting and this may have affected the results. Interpreting these results calls for caution and the consideration of the local context when developing and implementing IPV programs. The findings of this study suggest that the consideration of age as a factor associated with vulnerability to IPV, needs to be considered as a specific or contextual factor with potential variability across countries and settings.

These study results indicate that IPV is of concern in this urban setting in Maputo and emphasize the importance of early interventions in Mozambique, so that young women are made aware of the risk of IPV and are advised about how this could be prevented, and if violence occurs, how this should be handled. Efforts are required in order to enhance the young women's reproductive rights, so that young women in schools and communities can pursue healthy relationships free from violence.

Young women's HOH's unemployment status, partner employment status and partner more than ten years older. In the bivariate analysis, several of the risk factors which have been reported from other studies showed a similar trend in this study. Young women whose partners were more than ten years older than themselves and those who did not know the age of their partner were more likely to report IPV (OR, 4.528, 95% CI: 0.986–20.805, p = 0.052).

Similar findings are reported from a Botswana study, which revealed that large age differences between partners is a predictor for IPV [52]. Moreover, studies from South Africa and other SSA settings reported that women who have partners older than themselves struggle to air their opinions about relationships, and furthermore, the older partner may expose young women to risky behavior that includes violence [41, 46, 51].

Economic status has also been shown to be an essential factor associated with IPV. In the multivariable analysis, there was significant association between the financial situation of the HOH, if unemployed, and young women reporting IPV (AOR, 1.642 95% CI: 1.044–2.584, p = 0.032). This suggests that young women from households with unemployed HOHs have an increased likelihood of experiencing financial constraints, and therefore dating older men may result from the economic dependence of women.

Moreover, the bivariate analysis suggests that having a partner who is employed (OR, 2.247 95% CI: 1.87–4.256, p = 0.013) might lead them to tolerate and to remain in relationships with IPV, since employed partners are more likely to exert financial power over the women, and may even perpetrate violence against them. This was also a confirmed trend in the multivariable analysis which showed that the risk of abuse increased when the partner is employed (AOR, 1.675 95% CI: 1.044–2.584. p = 0.155).

Our findings follow previous studies which reported that adolescent, single young adults experiencing financial strain were more vulnerable to being abused [22]. This is also consistent with findings from South African adolescent learners that revealed a high risk of IPV among those adolescents not receiving pocket money from their parents, compared to those who were [46]. Findings on low socio-economic status and the increasing risk of IPV were also reported in studies from SSA and elsewhere [41] and in a Zimbabwean and Ghanaian Studies [48, 53].

Similarly, a survey conducted in 31 countries, including South Africa and Tanzania, evaluating IPV and economic status among college students, revealed that the higher levels of IPV were associated with an inability to meet daily financial needs and with being younger [54]. In

a study conducted in low-income and middle-income countries, the findings indicated that in general, richer and more empowered women reported less IPV [20]. A study conducted in South Africa found that IPV reduced with interventions combining education and economic empowerments. The violence experienced by women with their own income decreased by 55% (A0R = 0.45; 95% CI = 0.23, 0.91). There were also improvements in the women's ability to challenge the acceptance of violence and to leave violent relationship [55]. The results suggest that improving the socio-economic circumstances of women may improve women's independence and control over their lives, improving their skills to manage healthy relationships with no violence. Particularly among younger women, who are at the initiation stage of their relationship, their financial dependence might reduce their likelihood of leaving a relationship if there is violence.

Since many young women in schools are not working, the opportunity to remain at school may mean that they cannot leave the relationship. Young women are likely to date partners who are able to buy food, clothes, and other things. Further, young women under such conditions accept the violence that is perpetrated by their partners and this includes having sex when they do not want to and performing other sexual activities. Thus, the young women's reliance on partners, exposes them to a higher risk of IPV (Da Cruz et al., 2014). This understanding emphasizes the public health burden of IPV and its rationale among young women experiencing financial constraints in a developing country such as Mozambique. There is indication of an initiative aimed at improving the economic and financial status of women in Mozambique, through promotion of entrepreneurship and employment opportunities, as an element of the 2030 Sustainable Development Agenda. However, the reported "National Program for women's economic empower" was only launched recently in 2019, and it prioritizes the illiterate women from rural areas and is not addressing the needs of school going young women [56]. Notwithstanding this, there is a decade in which progress can be made towards the SDGs in Mozambique, and to develop targeted strategies towards the 2030 goals. The findings of this study contribute evidence-based information to advocate for specific prevention programs to improve the economic circumstances of young women in schools.

Community factors. *Religiosity*. Our multivariable analysis confirmed that the odds of experiencing IPV increased substantially among women who do not consider themselves committed to any religion, in contrast to their counterparts (AOR, 1.596, 95% CI: 1.009–2.525, p = 0.046). Being a person who follows religious principles suggests that these women were less likely to be involved in risky behavior, which can lead to IPV, or may suggest that they are more likely to use nonviolent methods when in conflict situations. In contrast to these results, a qualitative study among Togolese women reported a high tolerance of IPV among those who were committed to religion [57]. This could be because in some religion, women are supposed to respect and obey their partner at all times, and IPV may be acceptable according to such religious beliefs. For example, the findings exploring the links between religious affiliation and IPV among women in Ghana, reported trends in sexual and emotional IPV among women adhering to a religion, when compared to those not involved with any religion affiliation. However, they were at the same time less likely to report physical violence [53]. However, in the Mozambican context, there are many different churches and people can freely choose to attend whichever they prefer. Therefore, people who commit themselves to religious principles are less likely to be involved in risky behavior, including sexual and physical violence. However, they may at the same time, be more likely to be tolerant of violent behavior if their religion enforces gender inequalities and ideas about male dominance and female submissiveness [58]. Hence, religiosity may even hinder the women recognizing their risk and reporting the abuse if the religion's views accept violence and this may perpetuate IPV [59]. The differences reported in our results may be due the methods we used to assess religiosity. We assessed

religious commitment as a yes/no responses, which could have been too crude to provide sufficient information regarding religiosity as a risk or protective factor for IPV. The role of religiosity and its relationship to IPV in this setting appears to be complex and calls for further research on how religious values might shape social attitudes and perspectives on IPV. The various religions could also have a role in preventing IPV, through their social and cultural perspectives.

Through collaboration with community members, leaders and the educational sectors, IPV awareness and preventions strategies could be discussed and implemented taking into consideration both the needs of individuals and the community's religious values and the detrimental consequences of IPV on women and children.

Societal factors. *Young women's beliefs about male superiority*. In many traditional societies beliefs about male superiority remain strong, and the empowerment of women has proved to be a slow process (Shamu et al. 2015). Amongst the young women in our study despite their attending secondary school, in the bivariate analysis, a statistically significant association was found between experiencing IPV (OR 2.298, 95% CI: 1.014–5.210 p = 0.046) and their believing that "males are superior to females". The possibility of changing such beliefs is feasible since our results differ from studies done among adolescent learners in South Africa. Young women there reported empowered attitudes, disagreeing with male superiority, and these attitudes were associated with a reduced risk of being emotionally abused [46, 47]. This reduction in abuse can be interpreted either as an indication that such women may obey their partner and not argue, or it may be hypothesized that young women who disagree with ideologies of male superiority are more likely to manage conflicts by resolving them within the relationship. In these studies, although the attitudes of women who disagree with ideas of male superiority reduced their risk of emotional violence, they remained at risk of physical violence, emphasizing the importance of including both sexes in school-based and community-based initiatives to reduce gender violence. Of concern is that both the female and the male learners in a South African studies, advanced ideologies of entitlement and male superiority [46, 47]. These perceptions are very traditional and are found in many cultures. Such beliefs need to be challenged in order to achieve more egalitarian societies which respect and develop the contribution of women, who often constitute half the population. Such an approach is essential to reduce IPV and achieve the SDG 5.

Consistency regarding the association between the sociocultural factors and the risk of IPV has also been reported from SSA and elsewhere [41, 54] and in studies conducted in different countries in low-middle income countries, where empowered women were less likely to report IPV [20].

Many statements regarding gender issues were not found to be associated with IPV in this study. Further, the multivariable logistic regression analyses did not confirm the trends of the bivariate analysis. The likely reason for these results could be the setting where the study was undertaken, since schools are often where young women receive education and health promotion programs and this population is possibly more aware of the required social norms and gender issues.

The current prevention programs on partner violence in Mozambique indicate collaboration with the educational sectors to promote gender equality [60]. However, the findings from our study revealed a surprising and concerning high prevalence of IPV and this appears to indicate a gap among young women in schools, regarding their skills to challenge male dominance norms and to effectively prevent IPV. Further, obtaining information regarding health promotion and how to prevent risky behaviors and violence, proved to be difficult among the school going women in our study, as they explained after answering the questionnaire. This suggests that the existing sociocultural vulnerabilities among young women may result from

3248

the social context or environment where they are integrated, such as the community where they live, which may endorse strong ideologies of male dominance, rather than the educational setting. In Mozambique, concurrent gender norms which privilege male dominance over women still exist. For example, in some cultures, it is perceived as normal and acceptable for men to have more than one partner [36, 61]. These findings were consistent with those of a previous study evaluating the multisectoral response of gender-based violence (GBV) in Mozambique, which revealed that young women justified that a man has a right to have sex and that women should satisfy men at any time [23]. Such views are also consistent with studies done in similar settings [13, 20, 48, 53, 54]. Similarly, social norms of male dominance and the risk of IPV against women were also described in recent studies from Bangladesh [10], Vietnam [9] and Nepal [8].

The finding from our study raise concern about the young women's low gender empowerment attitudes and indicate an urgent need for the inclusion of education on gender equality early in the school programs and the importance of involving both sexes for effective results. Further a systematic review of studies conducted to evaluate preventive interventions on violence against adolescents and young girls in Lower Income Countries, including the SSA countries, pointed out that the persistent sociocultural factors may limit the success of prevention programs in these settings [4, 62].

There is thus a need for consideration of the contextual sociocultural environment and to include comprehensive programs that empower younger women with skills to challenge such negative gender norms when implementing IPV programs in schools. Comprehensive programs require collaboration with the community and the educational sector in working to change gender norms regarding male dominance. This can further improve social interactions and relationships and thus prevent violence and IPV.

Implications

This study has identified important factors associated with IPV and emphasizes the need to develop targeted programs to reduce IPV. Using the information obtained from this study interventions can be developed based on the data and which offer opportunities to work with young women attending secondary schools, to determine whether programs that address the protective variables are associated with reductions in IPV rates in young women. This cross-sectional research improved our understanding of the magnitude of IPV among young women and some of the contextual factors that need to be addressed. It has thus contributed information towards the development of the contextual preventive strategies required, since the study provided new insights and empirical data that can be used in developing programs to reduce IPV in the young women. The study has shown that targeted interventions should be initiated in secondary schools and evaluated. Based on these results the targeting of the interventions will need to be further developed and extended to young women not in school and to young women living in rural areas. In working to contribute to SDG 5 this cross-sectional study provides useful current information about the extent of the problem and makes recommendations as to how IPV among young Mozambican women can be reduced.

Limitations and strengths

As with most studies, this study had limitations. Firstly, as the study was based on young women's self-reported experiences of IPV, it is possible that some may have under- or over-reported their experiences, according to the perceptions that they attribute to IPV. The time factor is a further limitation, in asking them to think back over a year and over their lifetime. Secondly, the study is a cross-sectional design, which could not establish firm causal

relationships. Longitudinal studies, such as intervention studies, would be the next step and are needed to determine whether the protective variables identified are associated with reductions in IPV rates. Thirdly, the measurement of certain variables (e.g. alcohol use, the status of employment, religiosity) in a yes/no format may have been too crude to capture their association with IPV fully. Fourthly, data were collected only among secondary school-going young women in KaMpfumu District Municipality and thus excluded those who were not in school or those who had dropped out of school. This may limit the generalizability of the findings to all young women in Maputo. We did not find statistically significant results in most of our multivariable results, which could be due to the sample size power limitation, and we are aware that the relationships observed in our sample may not be found in all the population we intend to represent. Thus, this could limit the effectiveness of an intervention based only on the sample instead of the whole population. Further in this study we did not ask about childhood experiences of violence or previous exposure in their households to witnessing violence. The study benefited from the population proportional sample size, the random sampling method, the use of standardized, validated questionnaires and of stratified and multivariable methods of analyzing the results to reduce the effects of confounding factors. More studies with larger samples including specific variables affecting young women such as peer and parental influences, childhood experiences of violence, are needed to provide the basis for inference to the entire population, but this study provides a basis for the development of targeted interventions for young school going women.

Despite weaknesses, the strength of this study is its further confirmation of the findings from previous studies. The results from this study also provide new insights to contribute useful empirical data for programs which address interventions on IPV, especially for targeting young women in order to design better intervention and prevention measures.

Conclusions

We found a high prevalence of IPV in our study and report that psychological violence was the most prevalent form of IPV in all the age categories, followed by sexual and physical violence for both lifetime and twelve months' prevalence. Younger women (teens) were less likely to be abused compared to those older (20–24 years). IPV was highly associated with the low economic status of women, indicated if the HOH was unemployed. The odds of IPV increased among women whose partner was employed and there were trends of IPV if the partner was much older. The results also indicate an association between IPV and sociocultural factors resulting from the young women's lack commitment to religion and trends indicating increased odds of IPV among women agreeing with ideas about male superiority. The results from this study have identified the contextual socioecological factors interacting at individual, community and societal levels. The study emphasizes the need to develop and implement interventions early in the lives of young women attending schools and the consideration of a multilevel approach to address the socio-economic and cultural risk factors which emerged is important to include in such programs.

Although research linking the economic aspects with IPV is evident among the adult population, this study examined contextual factors among the specific group of school going young women in an urban setting. The study is an important step contributing to the field of IPV, by providing an understanding of the contextual risk factors, their role and how the interaction at individual, community and societal levels place young women at high risk of IPV in Maputo city.

The study findings are also noteworthy as an important contribution to the body of literature, as it investigated risk factors and also incorporated sociocultural factors influencing the

experiences of IPV among schooling young women aged 15–24 in Mozambique, not previously studied. The understanding of the cultural context may help to explain the occurrence of IPV and the responses needed, since in this setting, the majority of communities are dictated to by the social norms which give privilege to men's dominance over women, leading to gender inequalities and promoting IPV. This study is also important, given its focus on young women, who are a group that is affected by gender inequalities which result in an increased risk for IPV. Research concerning risk factors for IPV among young women aged 15–24 are standard in the setting of USA but less so in SSA, and this has not previously been undertaken in Mozambique. This study thus increases the current information by providing a unique context of sociocultural gaps which place young women at increased risk of IPV in the study setting.

In particular, the economic vulnerabilities within young women's families have important political implications and consideration of programs that bolster financial capital within households and communities, while integrating cultural beliefs and gender egalitarian notions. This study's findings provide the information required to enhance the existing programs in schools in Mozambique and emphasized the need to incorporate in such programs, strategies of women's economic empowerment and consideration of religious and cultural values.

Mozambique is committed to the 2030 targets for sustainable development, and the 2015–2019 and the 2020–2024 Government five-year programs, have integrated the strategic objective of gender equality and empowering women and girls [63]. Therefore, the study contributes to Mozambique's efforts toward achieving SDG 5, by providing the evidence-based information required to advocate for improvements in existing programs. The study findings call for involvement of all stakeholders and the need for consideration of the cultural and social dynamics and their implications, when addressing gender-based prevention programs. An integrated approach to ensure that no woman is left behind is required to end IPV among young women in Mozambique and contribute to the success of the 2030 SDG5.

Supporting information

S1 Appendix. English questionnaire. File with English questionnaire.
(PDF)

S2 Appendix. Portuguese questionnaire. File with Portuguese questionnaire.
(PDF)

S1 Dataset. IPV among young women in Maputo. File with data on IPV.
(PDF)

Acknowledgments

The authors would like to thank the respondents and research assistants for their participation.

The authors acknowledge the Instituto Superior de Ciências de Saúde (ISCISA), Maputo, Mozambique, the Netherlands Initiative for Capacity Development in Higher Education (NICHE) and the University of KwaZulu-Natal (UKZN), Durban, South Africa, for the provision of resources toward this article.

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3252

3253

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3260

CHAPTER EIGHT

SYNTHESIS

The study was undertaken to determine the prevalence and explore socio-cultural factors influencing intimate partner violence among young women aged 15−24 years old in KaMpfumu district, Maputo city. Although young women are experiencing IPV, there is insufficient evidence to guide the development of interventions to mitigate IPV among such young women, where IPV in the city of Maputo remains a concern.

The objectives of the study were thus:

- To conduct a scoping review of the evidence of socio-cultural factors influencing intimate partner violence among young women in SSA
- To explore individual and socio-community factors influencing intimate partner violence among school-going young women in KaMfhumu district, Maputo city
- To investigate the prevalence of physical, sexual and psychological violence among school-going young women in KaMfhumu district, Maputo city
- To identify contextual risk factors associated with intimate partner violence among young women in KaMphumu district, Maputo city
- To inform a model of a preventive intervention to target young women in Maputo city

This study used a sequential exploratory mixed methods strategy to explore factors influencing IPV among young women. The study was underpinned by the Socio-Ecological Theory (1). This theory explains violence against women due to multiple factors interacting at the individual, relationship, community and societal levels.

Initially, a scoping review was undertaken to understand the gaps in available information for this target group of young women of 15−24 years attending high schools in Maputo, Mozambique. This information was used in the qualitative exploratory study using FGDs undertaken with young women attending secondary schools in the KaMfhumu district.

Through analysis of the FGDs, themes were generated explaining the young women's views on IPV. Based on these themes, a questionnaire was adapted using the WHO Multi-country tools used in the surveys of violence against women (2, 3), and this was used for data collection in the quantitative phase, which provided numerical evidence of the problem.

The use of mixed methods, which included both qualitative and quantitative approaches, assisted in providing a comprehensive account of the IPV among 15−24 years old school going young women. The prevalence of IPV and the associated factors were assessed, and an effective method of including young women in interventions to prevent IPV has been suggested.

The last objective (Objective 5) is to inform a model of a preventive intervention addressing young women in Maputo city.

Mozambique has defined policies and interventions to reduce IPV (8-10). From the high prevalence of IPV reported in this study, the policymakers and program managers need to use the findings of this study to re-assess how such intervention programs can be improved and new measures to reduce the prevalence of IPV. The study emphasizes the need to develop and implement interventions early in the lives of young women attending schools and the consideration of a socio-ecological model to address the contextual factors at different levels, including the individual (economic, alcohol), community (religiosity) and societal (gender norms).

8.1 Main findings

Before collecting the data, the PhD student investigated the available information regarding IPV amongst young women in Mozambique and other countries in SSA. This review identified a scarcity of evidence about the socio-cultural factors associated with IPV among young Mozambican women. These findings from this review indicated factors linked to attitudes of males having multiple sexual partners, payment for marriage, women's attitudes towards having an older partner and who uses alcohol, the low economic status of women and childhood experience of violence.

The research on socio-cultural factors influencing IPV among young women did not cover Mozambique, which has had a different history from many other SSA countries (4-7). This study was thus undertaken since, from the review, there was a need to use different methods and reference standards, including direct measures of the violence experienced by young women in Mozambique. This was also emphasized by the data from the FGDs, which provided detailed information about IPV.

The section discusses the quantitative and qualitative results from the study that explain the contextual socio-cultural factors associated with IPV.

These findings demonstrated that the socio-cultural factors influencing IPV among young women are not isolated but rather that they are interconnected at different levels in the socio-ecological system

The qualitative study (paper 3) results revealed four main themes that emerged from the data and included: 1) (Individual level), related to knowledge of young women about IPV through witnessing friends being physically abused by their partners, from friends sharing personal experiences of IPV and experiencing the accepting attitudes of their mothers toward IPV; The meanings that young women give to the occurrence of IPV viewed as a violation of the human rights of women; The alcohol use a contributing factor for IPV and the economic status of women leading to acceptance of IPV. 2) (Relationship level) related to the Influence of friends. 3) (Community level) related to Religious beliefs that placed men at the head of the social order above women and 4) (Societal level) related to Factors promoting acceptance of IPV, and these included social acceptance of violence and the male chauvinism; The recommendations advocated by the young women to prevent IPV and this included the promotion of awareness about IPV and use of support services for the victims and the need to create specific IPV counselling centres for young women to meet their needs and to allow the counsellors to screen for other potential sexual and reproductive problems which affect young women.

The FGDs described young women's knowledge about IPV through witnessing friends being physically abused by their partners, from friends sharing personal experiences of IPV and experiencing the accepting attitudes of their mothers toward IPV. The young women's personal experiences at home and friends' experiences shaped their views and expectations about IPV.

The FGD participants further mentioned the influences of friends. They explained the peer pressure that young women experienced and that young women are more likely to imitate their friends' and peers' actions. They further mentioned that when young women are faced with abuse in their relationships, they seek advice from their friends. Friends are more likely to advise them to maintain the relationship rather than helping them to solve the relationship problems, and thus, the abuse continues. These findings mirror studies conducted by (Chernyak, Ceresola, & Herrold, 2020; Shamu et al., 2016) (15, 16).

The findings also highlighted young women's knowledge about IPV, which was mainly orientated towards physical abuse by a male partner with less emphasis on psychological abuse. This finding confirms studies that have been conducted on IPV among older and young women. Most of these

studies show that physical violence is one of the most frequently reported forms of violence used to inflict pain (6, 7, 12, 16).

From the review of the literature (Paper 2), the findings highlighted an increase in the prevalence of IPV in SSA settings (3, 6, 7). Furthermore, this review of the literature provided evidence concerning the widespread of IPV among young women (11-14). This was further emphasized in our study of school-going young women living in Maputo.

In the survey (paper 4), the high prevalence of IPV among young women attending high schools was the concern. Of the 413 young women who provided information about their experiences of IPV, 248 (60.0%) (95% CI: 55.15-64.61) were found to have experienced at least one form of IPV in their lifetime.
The prevalence in the 12 months before data collection was 186 (63.4%) (95% CI: 57.68-69.00).
Psychological violence was predominant with the prevalence of 230 (55.7%), followed by sexual violence 120 (29.1%) and physical violence 93 (22.5%).
The overall prevalence of IPV increased with age, 209 (57.9%) between the ages of 15 and 19 years and 39 (75.0%) between 20 and 24 years.
Further, young women mainly reported experiences of Psychological abuse.
Psychological abuse needed more attention in this study since this gap is likely to impact the young women's awareness and understanding of IPV and their ability to prevent this form of abuse.
Since young women are at a stage where they are initiating relationships, they need to understand the implicit and explicit forms of IPV and the effects on their psychological development (17). The opportunity to improve young women's awareness about IPV and its psychological, physical and sexual forms of abuse can be undertaken during health promotion activities.
The findings from this study are in line with previous studies in Mozambique (4, 5), and the SSA estimates including Ethiopia, Namibia, Tanzania, Zimbabwe, Rwanda, South Africa, where the prevalence among young women aged 15−24 ranged between 19% to 66 % (6, 7, 12). The prevalence in our study is somewhat higher than the findings from a study in the United States of America (USA), where the range was between 8% to 51.2% (18-21).
Comparisons between our study and other studies from different settings are challenging due to the different measures used for IPV and the different time periods.

For example, in South Africa, a study involving 2 115 learners, which measured IPV prevalence over 12 months using an interview administered questionnaire, reported a prevalence of 30.9% (16).

In a study from Tanzania among a sample of 226 young men and women, the young women aged 15–30 years reported an overall prevalence of IPV measured in the previous 12 months of 35.8% (22). In another study conducted in South Africa, the data regarding the prevalence of IPV over three months which were collected through self-completed interviews among a sample of grade 8 students, reported a prevalence of 39.1% (23).

In a study carried out among Jordanian college women aged 18−24, the self-reported prevalence of IPV was 30.0 % (21).

The higher prevalence found in our study may result from our efforts to ensure a comprehensive questionnaire, thorough training of the data collectors, and a robust data collection method. The data were collected in an environment that provided privacy, which may have contributed to the participants disclosing their experiences of IPV.

The high disclosure rate may also be attributed to the method used to collect data consisting of confidential self-responses. Young women are more likely to provide valid responses if the questionnaire is confidential and anonymous (24).

The young women views on IPV (paper 3) reflect the context of broader individual and socio-cultural factors affecting individuals and communities. The individual factors, reporting points of view of young women on IPV, explained the meanings that the young women give to the occurrence of IPV as a violation of women human rights. Participants further considered IPV a response associated with alcohol use by both female and male partners and with the economic status of women. The participants' views on IPV and the reasons indicated for the acceptance of IPV by young women may explain the vulnerabilities affecting young women and shape the set of risk factors investigated in this study. This was emphasized in FGDs, as viewed from the perspectives of the young women, complex individual (economic; alcohol; age), community (religious beliefs), and societal (the male chauvinism and the social acceptance of violence) factors promoted acceptance of IPV.

After that, the quantitative findings from the survey explained the factors associated with IPV by providing the statistically significant variables. In terms of the socio-ecological model, the contextual

factors associated with IPV were individual (economic; age), community (religiosity) and societal (gender norms).

The triangulation of the findings of the two phases included a comparison with the literature. It helped to better understand both the extent and context in which IPV was occurring and the factors associated with this, as further described below:

Individual

a) The meaning that young women give to the occurrence of IPV is viewed as a violation of the human rights of women

Participants in the FGDs, (paper 3) discussed the problem of IPV as affecting young women. They indicated that this is a violation of women human rights and occurs early among women in their communities. The participants felt that young women are overpowered by their partners in decision making, as they lack the power to make decisions about the relationship, and as such, they struggle to exercise their rights. This was seen as a problem limiting young women's ability to avoid IPV since they may lack skills in resolving conflicts and making informed decisions to prevent IPV, especially when it comes to sexual violence perpetrated by their partners. The participants mentioned that young women lack the confidence to confront their partners and feel obliged to fulfil their demands, no matter how toxic the relationship becomes.

Our study, however (paper4), revealed that the odds of being abused were lower among younger women (15–19), (OR, 0.458, 95% CI: 0.237−0.888, p=0.021), as compared to those older (20–24) years. These results suggest that women in their early twenties may be more time exposed to relationships and conflicts. They may be more likely to tolerate IPV and to remain in a relationship if there is violence since they may be married or in committed relationships. In comparison, younger women are at the initiation stage of their relationships and probably less time exposed to relationships and conflicting relationships. Therefore, they may be less likely to be committed to staying in such a relationship when there are conflicts.

This is consistent with previous studies done in Mozambique among ever married or cohabiting women in a population-based survey issued in 2011 (5). For example, in Mozambique, a study among women aged 15–49 years attending schools and universities revealed that adolescent and young women aged 15−24 were more vulnerable to violence than women above 24 (4).

In the context of South African and USA settings, for example, the findings suggested that the young age of women reduced their ability to deal with the complexities and the dynamics of relationships, therefore increasing their risk for IPV (12, 16-18, 23, 25).

The likely reasons for the differences in the different studies' results concerning the age of the women experiencing IPV may be the selection process for the study samples and the comparisons between different age categories. Our study recruited only school-going women between the ages of 15 and 24 years, while other studies included young women and women above 24 years.

In Mozambique, a developing country, children often enter school when they are older than is typical in other countries and continue to attend school above the age of 20.

The high prevalence of IPV reported by the young women emphasizes the need for specific intervention strategies to address potential risk factors and prevent the occurrence of IPV early in young women's lives (26).

The consideration of age as a factor associated with vulnerability to IPV needs to be considered as a specific or contextual factor with potential variability across countries and settings (7).

Although our results show that IPV is mostly reported among older young women compared to the youngest, it would be possible that the youngest women would not be open to disclosing it. Therefore, the early experiences of IPV among young women emphasize the need to address IPV among young women of all ages (15−24) (7, 12, 27, 28).

b) Alcohol use and IPV

Although the use of alcohol was not found to be statistically significant in the survey, the participants in the FGDs highlighted it as a cause for concern in that alcohol consumption by both partners might result in IPV. This could be due to reducing one's inhibitions resulting from alcohol consumption leading to an increased propensity to violence, resulting in physical and sexual abuse (29). Participants viewed the effects of alcohol as a potential contribution to violent behavior. There was a consensus among the participants of the adverse effects of alcohol and that men use alcohol to gain more control over their partners. As the weaker sex, Young women are powerless and are further humiliated and compromised as a result of this. Participants further discussed the risky behaviours affecting youth in societies due to the use of alcohol. Participants mentioned that young women prefer

and are encouraged to consume alcohol, which encourages the loss of inhibitions, leading to risky behaviours, including violence and undesirable sexual activities, such as unsafe sex.

The alcohol consumption highlighted in the FGDs was associated with male controlling behavior. Any controlling actions forced on the female partner, if challenged, may lead to IPV. Further, participants mentioned that young women both prefer and are encouraged to consume alcohol, which encourages the loss of inhibitions.

Alcohol consumption by both males and females has also been reported in many studies associated with risky behaviors, such as unsafe sex, undesirable sexual activities and IPV (16, 29, 30).

In Mozambique, alcohol consumption amongst high school learners has been previously reported as a concern and requires immediate attention (4, 31). The report published by the Department of Drug Prevention in partnership with the Directorate of Education in Maputo-Mozambique, showed learners (females and males) in high schools, including two schools in the study setting, appearing in classes under the influence of alcohol and drugs (31).

It is thus crucial to tackle alcohol use among young people in and out of school to reduce risky behaviors and IPV (32).

c) Low economic status of women

Most participants in the FGDs revealed that the poor economic status of young women is one of the critical reasons for the acceptance of IPV. As young women growing up in a modern consumer society, they needed various items that they and their families could not afford. For such reasons, their peers date older men who are experienced in relationships.

Transactional sex among young women was seen as the answer to accessing such commodities, as the male partner provided such. The participants considered that this situation was an enabler of IPV. Because the young women were not working, they believed that coping without a partner would not be easy for them. The participants explained that because the young women's partners buy food, clothes, and other things, women do not have a choice but to accept the violence their partners perpetrate.

Notwithstanding, unemployment is high in Mozambique. Although about 3,4% of young people aged 15−24 (33), young women attending school are unlikely to find part-time employment. They are thus reliant on family members or employed partners.

Paper 4 reported the increased odds of abuse among young women experiencing financial constraints. This was reflected in the significant association between the financial situation of the unemployed HOH and young women reporting IPV (AOR, 1.642 95% CI: 1.044–2.584, p=0.032). The bivariate analysis indicated that having an employed partner (OR 2.247 95% CI: 1.87−4.256, p = 0.013) might double the risk of IPV since it may lead them to tolerate and to remain in relationships with IPV. Further, young women whose partners were more than ten years older than themselves were more likely to report IPV (OR, 4.528, 95% CI: 0.986–20.805, p = 0.052). The quantitative analysis thus confirmed the results of the FGDs.

These findings, therefore, suggest that young women from households with unemployed HOH have an increased likelihood of experiencing financial constraints and, therefore, dating older and employed men, which may result in the economic dependence of the young women (4, 6, 12, 23, 27). Young women with older partners may have difficulty presenting their views and airing their opinions about the relationship. Furthermore, the more senior partner may expose young women to risky behaviour that includes violence (12, 17, 22). For example, young women who want to use protective measures such as condoms and contraceptives must get approval from their older partners. The latter are not always willing to use such protective measures (34-37) (19).

Women experiencing IPV are likely to have more transactional sex (17, 35). With the current prevalence of epidemics such as HIV, they might be at increased risk of HIV through violent or undesirable's sexual intercourse and through their reduced ability to negotiate condom use (34, 38, 39). Their reduced power to prevent HIV may also result from their low awareness of HIV prevention programs (34, 38, 40). It is thus crucial to address GBV and IPV prevention to reduce HIV risk among women (26).

Therefore, having an employed partner might lead young women to tolerate the violence and remain in relationships with IPV since employed partners are more likely to exert financial power over women and even perpetrate violence against them (6, 7, 12, 17).

Our findings were consistent with previous studies using different study designs ad methods.

A consistent finding was that economically dependent women were more likely to accept and experience IPV (4, 17, 41). This contrasted with the financially independent women who were less likely to accept violence (5).

A study evaluating the characteristics of partner violence among university students aged 15−45 in Mozambique revealed that the risk of IPV among the participants was increased by factors such as males having more than one sexual partner, the female having experienced financial constraints and dating older and employed partners (4).

Since many young women in schools are not working, the opportunity to remain at school may mean that they cannot leave the relationship (16). Therefore, young women are likely to date partners who can provide goods (4). Young women under such conditions accept the violence perpetrated by their partners, including having sex when they do not want to and performing other sexual activities (4, 17, 23).

The findings are also consistent with findings from South Africa, where adolescent learners revealed a high risk of IPV amongst those who were not receiving pocket money from their parents (16). Similarly, in studies conducted in 31 nations, including some SSA countries (South Africa and Tanzania), and even in South American and Asian settings (Peru, Brazil and Bangladesh), among young women aged 15−24, there were significant associations between the low economic status of women and their acceptance of violence (42).

For example, a survey among college students revealed that the higher levels of IPV were associated with an inability to meet daily financial needs and being younger (19). Interestingly a study conducted in South Africa found that IPV reduced with interventions combining education and economic empowerment. The violence experienced by women with their income decreased by 55% (A0R=0.45; 95% CI=0.23, 0.91). There were also improvements in the women's ability to challenge the acceptance of violence and to leave a violent relationship (43).

We are aware of the limitation for analysing these risk factors since the study did not explore whether those young women living in households with an unemployed HoH were also likely to be dating employed men or men older than ten years. However, on data collection, the questions were explained to the participants that the head of household is the one who is responsible for providing subsistence for their household, either a partner, a father, a mother or another person.

The study explored the data on the head of household employment status (56.0% employed) and partner employment status (14.7% employed), but we could not distinguish whether the partner was also the head of household. The results show that the economic status of women is an essential factor associated with IPV. This understanding emphasizes the public health burden of IPV and its rationale among young women experiencing financial constraints in a developing country such as Mozambique.

Community factors

d) The religious beliefs that placed men at the head of the social order above women

The FGD participants discussed religiosity and IPV. They reported their concern that being a believing woman who lives according to her religious principles may be disadvantaged in relationships since this can lead to acceptance of IPV. They further explained that women exposed to IPV might be tolerant of such abuse if they endorse the belief that males have the right to make all the decisions, which may perpetuate violence.

The perpetration of IPV is encouraged by religious institutions promoting norms that require females to be submissive to their partners. They complained that such churches endorse the religious beliefs of male superiority and use them against women. Religious beliefs and attitudes in communities form an essential environment where social networks and social norms are created. These norms have the potentiality to protect women against partner violence. They may also promote community and social norms that drive violence (44).

Therefore, religiosity and community culture are an essential context in which the various stakeholders, including community and faith leaders, can address activities to prevent IPV. Such actions may require a widespread cultural change across families, communities and society (45).

Our multivariable analysis (paper 4) confirmed that the odds of experiencing IPV increased substantially among women who do not consider themselves committed to any religion, in contrast to their counterparts (AOR, 1.596, 95% CI: 1.009–2.525, p=0.046).

Spiritual well-being is an essential element of health, and churches exist to provide this service. In support of these results, a qualitative study among Togolese women reported a high tolerance of IPV among those committed to religion (46). This could be because women are supposed to always show

respect and be obedient towards their partners in some religions. IPV may be acceptable according to such religious beliefs.

Another example was the finding from a study exploring the links between religious affiliation and IPV among women in Ghana (47). The women committed to religion were less likely to openly disclose IPV, but this was not the case amongst those not committed to any religion (47). A probable explanation for these findings is that the women who endorse religious beliefs may fear being blamed and shamed in reporting the violence perpetrated by their partners if their society knows them to serve God. At the same time, they may be tolerant of violent behavior if their religion enforces gender inequalities and ideas about male dominance and female submissiveness (48).

There are many different churches in the Mozambican context, and people can freely choose to attend whichever they prefer. Therefore, the role of religiosity and its relationship with IPV in this setting appears to be complex and calls for further research on how religious values might shape social attitudes and perspectives on IPV (45).

This study findings, therefore, suggest that the various religions could have a role in preventing IPV, through their social and cultural perspectives. These would require collaboration with community members, leaders and educational sectors in addressing IPV awareness and developing targeted prevention strategies that consider how to protect individuals, despite the community's religious values. Such communities may not openly support IPV, but the culture within their religious communities may ignore the occurrence of IPV.

Societal factors

e) Social acceptance of violence and male chauvinism reinforce male superiority over women.

In exploring the environment in which young women are situated, young women's views (paper 3) are that social acceptance of violence entrenches the vulnerability of young women and promotes their acceptance of IPV.

FGD Participants argued that one of the socio-cultural factors that influence violence is prejudice perpetrated by men against women within their communities.

In the Mozambican context, interpersonal violence, including violence between partners, remains a serious problem and women who grow up in these communities are socialized to accept violence as a norm (49, 50).

In Mozambique, the law on domestic violence, which aims to protect the victims of gender-based violence, exists (10). However, few available programs or actions empower communities to work against this practice (51).

Further participants in the FGDs had discussed the concept of male chauvinism, which privileges male dominance over women, as an essential and negative cultural trait evident in society.

The FGD participants mentioned that in their context, it is accepted as a social norm that a man can have multiple partners, and males are said to have the right to date more than one woman. This is likely to promote disharmony and may lead to violence (41, 49, 50). Further, with the current prevalence of epidemics such as HIV and other sexually transmitted infections, the risk of multiple sexual partners can affect the health outcomes of all women (36, 38, 39, 52, 53).

Cultural practices such as lobola, where the families of the brides receive gifts and money, and in exchange, their daughter joins the husband's family, was reported by women as promoting violence. The rationale for this is that some families do not allow their daughters to divorce when their partners are abusing them because of the stigma and the fact that they would need to return the acquired lobola (49, 54, 55).

This was seen as a cause for concern, as it entrenched the status quo, which diminished the status of women and IPV may be seen as a social construction derived from the social structure which supports gender inequality and masculinity norms (50).

In a society with a high prevalence of IPV, these cultural practices further hinder young women's progress (5). Thus, it is urgent to provide the evidence to inform interventions which need to include law enforcement strategies and programs (including school programs) that stress human rights, gender norms and disapproval of violence through the communities and the social structures to ensure social support for prevention of IPV in Mozambique (56).

Many statements regarding gender issues taken from the WHO's international questionnaire (paper 4) were not associated with IPV amongst the young women in this study. However, a statistically significant association was found between beliefs about male superiority and young women's experience of violence, as described below.

In the bivariate analysis amongst the young women in our study despite attending secondary schools, a statistically significant association was found between experiencing IPV (OR 2.298, 95% CI: 1.014–5.210 p = 0.046) and their belief that "males are superior to females".

In Mozambique, current gender norms privilege male dominance over women. Two studies revealed that it is perceived as normal and acceptable for men in some cultures to have more than one partner (49, 55).

The findings from another study revealed that young women justified a man's right to have sex and that women should satisfy men at any time (41).

Such views are consistent with studies done in similar settings such as Tanzania, South Africa, Ethiopia and Kenya (12, 57), from Tanzania (22), Botswana (54), Togo (46), Uganda (17). These all highlighted persistent social norms of male dominance still prevailing in societies deemed to influence IPV. Similarly, social norms of male dominance were also described in studies from Bangladesh (58), Vietnam (59) and Nepal (60).

Our results differ from studies done among adolescent learners in South Africa, where some young women reported empowered attitudes and non-acceptance of male superiority. Such attitudes were associated with a reduced risk of being emotionally abused (16, 23). These South African findings can be interpreted as an indication that such women may obey their partner and not argue, or it may be hypothesized that young women who disagree with ideologies of male superiority are more likely to manage nonviolent conflicts by resolving them within the relationship. However, these results are from a single study in one area of the country. It will be interesting to see if these results are replicated elsewhere in South Africa.

Although current prevention programs on partner violence are considered in the Mozambican educational sectors to promote gender equity (8, 61), the findings from our study revealed a high prevalence of IPV. This prevalence among school-going young women may indicate a lack of skills to challenge male-dominant norms that may influence the prevention of IPV.

The findings from our study also raise a concern about the social acceptance of gender-discriminatory norms and young women's low gender empowerment attitudes. These indicate an urgent need to include education on gender equality early in the school programs and the importance of involving both sexes in such intervention programs.

Further, a systematic review of studies conducted to evaluate preventive interventions on violence against adolescents and young girls in LIC, including the SSA countries, support these findings and pointed out that the persistent socio-cultural factors may limit the success of prevention programs in these settings (13, 14, 26, 40, 52).

There could be methodological issues in the fact that in the quantitative study, the AOR did not highlight socio-cultural and community norms. It is possible that young women did not identify with the questions we asked or how we asked the questions. The FGD participants indicated that social norms were driving IPV. They explained that the "real situation on the ground" was that socio-cultural, community, and social norms critically influence IPV against women and these schoolgirls. The young women spoke against the belief in male hegemony and the traditional masculinities prevalent in their communities (41, 49, 50).

f) The recommendations advocated by the young women to prevent IPV

The FGD Participants further recommended interventions that can be used to prevent IPV. The recommendations advocated by the young women to avoid IPV included the promotion of awareness about IPV and use of support services for the victims and the need to create specific IPV counselling centres for young women to meet their needs and to allow the counsellors to screen for other potential sexual and reproductive problems which affect young women.

The FGD participants expressed concern that was a need for reliable referral services for this specific population group of young women in which IPV and other sexual and reproductive concerns could be addressed.

In Mozambique, as in many other African countries, the services to address IPV are not specific for young women (62-64). The opportunity for those young women in dating or in occasional relationships or those initiating relationships and experiencing IPV to seek help may be limited. Services are required to seek help, disclose IPV and other potential problems related to their sexual health and human rights (65).

Concerted and improved awareness campaigns advertising the available services that support the communities would help young women reach the counselling centres (27, 66).

Although the qualitative study did not access reporting of IPV experienced by young women, the high prevalence of IPV reported among young women in this study suggest gaps among young women to prevent IPV and therefore advocate new approaches and programs to meet young women's needs and to enhance the reporting and prevention of IPV advocated by FGD participants.

These new structural programs should consider the multifaceted determinants often associated with the cultural and structural constraints within micro, exo and macro systems, affecting this specific population group as revealed in this study.

It is essential to take cognizance of young women in their contextual environment in order to empower them with the necessary knowledge and skills that can reduce their vulnerabilities (40, 67, 68).

Since there are services available specifically to address adolescents and young people's sexual and reproductive health, this provides an opportunity that should be grasped to extend the awareness, prevention and support programs to prevent IPV in young women (69, 70).

8.2. Novelty of the study

The results of our study indicate a very high prevalence of IPV in Mozambique among school-going young women aged 15-24 years old.

This study is the first in Mozambique that has reported the lifetime and the current prevalence as measured in the previous 12 months of physical, sexual and psychological violence, focusing on ever partnered young women aged 15−24 years.

Previously, the prevalence of IPV among school-going young women in Mozambique was unknown, but this study has provided new information.

To date, the available estimates regarding the prevalence of IPV only covered ever married or cohabiting women between the ages of 15−49 (5); Partner and non-partner violence among young and adult university students between the ages of 15−49 years (4) and partner violence among clinical adult women (71, 72).

The study findings are noteworthy as an important contribution to an improved understanding of IPV in young women. It explored the dynamics of IPV in young women aged 15−24 by obtaining their views and perspectives.

In SSA, where countries have undertaken research, most were concerned with the prevalence and associated factors (3, 6, 7). This study also provides the perspectives of young women.

Our approach included FGDs with young women regarding their views, which increased the understanding about the knowledge of young women about IPV, the importance of their mothers' attitudes, and their knowledge about and attitudes towards IPV, also from witnessing their female friends' experiences.

Moreover, research findings concerning socio-cultural factors influencing IPV among young women aged 15−24 years are well documented in North America and growing emerging evidence in SSA. However, providing solutions to address the issue remains a problem.

However, the underlying factors in such contexts appear to have similarities in that the home environment moulds the young women's later experience of IPV. These include if children witnessed violence between parents and having experienced violence in their childhood (6, 15, 73, 74).

This study thus increases the current information by providing a specific context of socio-cultural factors which place school going young women at increased vulnerability to IPV. These describe, in particular, the economic vulnerabilities within young women's families, the religiosity, and the beliefs about male dominance.

8.3. Strengths of the study

The KaMfhumu District is the most urban area of Maputo city. The district of KaMfhumu is the leading financial, corporate, and commercial centre of the country and has the highest educational accessibility.

KaMfhumu attracts workers and students from the surrounding areas. Its metropolitan area is populated by people from different backgrounds, economic classes, cultures, and diverse perspectives concerning their health-seeking behaviors.

We used qualitative and quantitative methods to comprehensively explain the factors associated with IPV among these young women.

The FGDs method provided rich information from the participants regarding young women's perspectives, feelings, and views about IPV and the actions that should be taken to reduce IPV (discussed below). The information from the FGDs was used to develop further the survey questionnaire completed by the young women (75).

The use of mixed methods also strengthened the consistency of the findings due to the triangulation of the results, which included the published scoping review of the literature.

Thus, this study has provided new insights and empirical evidence for programs addressing interventions on IPV targeting young women.

The use of a population proportional sample size, the random sampling method and the use of standardized, validated questionnaires, and thereafter, the use of stratified and multivariable methods of analyzing the results and reducing confounding factors, followed by triangulation of the results may allow the generalizability of the findings to similar populations and settings. However, the study also had limitations, which are described below.

8.4. Limitations of the study

We focused our study on young women attending classes in secondary schools. In Mozambique, a developing country, children often enter school when they are older than in other countries and continue to attend school when over the age of 20 years.

Although the literature shows that schools are not necessarily linked to social structures, we conducted the study in a school setting, hoping that we would find young women aged 15−24. Thus, this has limited the investigation regarding the context, as the study focused only on young women attending classes in schools and not on young women out of school.

We are also mindful that young women who attend schools are probably aware of IPV and more likely to discuss IPV. In contrast, those who are not at school are perhaps less informed about IPV as a social problem and to have considered the socio-cultural perspectives. Hence, this may limit the transferability of findings to all young women in Maputo city and other Mozambican cities, not at school.

Out of 7 schools, four schools did not have the age groups targeted (15−24 years old). Only three schools were selected. This may limit the transferability of findings to all young women attending secondary schools in Maputo city.

The participants in the FGDs were between 15−22 years, attending daily classes. This may have limited the ability of the study to obtain the views of possibly married women of that age or other women of that age not at school but in a committed relationship, as well as employed women, who may have been working at the time the FGDs were held. The high unemployment in Mozambique suggests the number of such women may be limited (33).

Since the FGDs method lacked privacy, the confidentiality of the information could not be guaranteed. Notwithstanding, the experience of IPV could constitute an emotional constraint issue.

Although this had been explained to the participants, it may have limited the participants' ability to disclose their personal experiences of IPV (75).

Only 16 FGDs in 3 affluent schools and results are from a small quantitative study. The expected variables were not associated with IPV.

Since the quantitative data was based on self-reported responses, it is possible that some women may have under or over-reported their responses according to the perceptions that they attribute to IPV, and the social desirability of such responses. Moreover, the measurement of certain variables (e.g., alcohol use, the status of employment, religiosity) in a yes/no format may have been too crude to fully capture their association with IPV.

The study was a cross-sectional design which could not establish firm causal factors.

In this study, we did not ask about childhood experiences of violence or previous exposure in their households to witnessing violence and the personal use of alcohol. More studies with larger samples, including these specific variables affecting young women such as peer and parental influences, childhood experiences of violence, the female use of alcohol, are needed to provide the basis for inference to the entire population. Still, this study provides a basis for the development of targeted interventions for young school going women.

We did not find statistically significant results for most of our multivariable results, which could be due to the sample size power limitations, and we are aware that the relationships observed in our sample may not be found in all the populations we intend to represent. Thus, this could limit the effectiveness of an intervention based only on the sample instead of the whole population.

Could there be methodological issues in the fact that in the quantitative study, the AOR did not highlight socio-cultural and community norms. It is possible that young women did not identify with the questions we asked or the way we asked the questions. The focus group discussions indicated that social norms were driving IPV. They explained that the "real situation on the ground" was that socio-cultural, community and social norms critically influence IPV against women and against these schoolgirls.

CHAPTER NINE

CONCLUSIONS AND RECOMMENDATIONS

9.1 Conclusions

This study has reported the high prevalence of IPV affecting young women (15−24 years) in Mozambique. Since women form 51.5% of the population (33), it highlights that urgent measures are required to reduce the prevalence of IPV so that women's physical and mental health can be protected.

It emerged from this study that younger women (15−19 years) were less likely to be abused than those who were somewhat older (20−24 years).

IPV was significantly associated with the low economic status of the women, which was indicated if the HOH was unemployed.

The odds of IPV also increased among women whose partner was employed, and there were trends of IPV if the partner was much older.

The results also indicate an association between IPV and the young women's lack of religious commitment and trends indicating increased odds of IPV among women agreeing with ideas supportive of male superiority.

The study has thus confirmed that contextual socio-cultural gaps may hinder the programs aimed at preventing IPV among younger women if these are not addressed.

The findings also highlight the contributions of socio-ecological factors interacting at individual, community and societal levels in fostering IPV in Maputo. Therefore, we suggest using a multilevel approach targeting individual, community and societal levels to institute contextual and targeted control strategies.

9.2 Recommendations

Our study findings may add to a national strategy on GBV, particularly in IPV among young women. Using the information obtained from this study, interventions can be developed based on the data and offer opportunities to work with young women attending secondary schools, to determine whether programs that address the protective variables are associated with reductions in IPV rates in young women.

Given the adverse health outcomes associated with IPV, our findings support the inclusion of young women in IPV prevention programs. Findings suggest the need for integrated health education, economic and social empowerment and GBV prevention programs. Findings also highlight the need to include community and the educational sectors and work with both young girls and boys, the parents/families in the IPV prevention programs.

The design and delivery of awareness and prevention programs ought to be cognizant of contextual socio-cultural factors related to the young age of women in relation to the partner, the low economic status, religiosity and gender norms that may hinder the implementation of initiatives.

These factors are essential for efforts towards IPV prevention among young women. They need to be considered to safeguard the physical, sexual and emotional wellbeing of young women in Maputo city. In particular, the economic vulnerabilities within young women's families have important political implications and consideration of programs that bolster financial capital within households and communities while integrating cultural beliefs and gender-egalitarian notions.

9.2.1 General recommendations

The study found a high prevalence of IPV among school-going young women and has identified associated socio-cultural factors. Therefore, it is crucial to address such factors relating to young women and design and apply effective strategies to achieve wide and sustainable coverage to reduce/prevent IPV in this setting.

The study has shown that targeted interventions should be initiated in secondary schools and evaluated. Based on these results, the targeting of the interventions will need to be further developed and extended to young women not in school and to young women living in rural areas. Collaborating with local stakeholders working on GBV, including the Departments of Education, Health, and Gender, women and child sectors, and community and non-organization sectors, may be useful to attain universal access to young women.

Therefore, we suggest using a multilevel approach targeting individual, community and societal levels to institute contextual and targeted control strategies. This will include the high-risk groups (15−24 years old) in the prevention programs which target individuals and communities.

To date, there is no available evidence of the implementation of specific interventions to address IPV among young women in Mozambique. Hence the country is still grappling with ideas about effective strategies to reach the 2030 goals.

Notwithstanding this, there is a decade in which progress can be made towards the SDGs in Mozambique. These findings provided crucial evidence-based information to advocate for specific programs targeting young women in schools to reach the targets of 2030 (76).

This "Agenda" aligns with the gender equality and women empowerment goals to end violence against women and girls. Thus, IPV prevention programs urgently need to incorporate innovative approaches conceptualizing interventions that include individual, micro, macro and Exo systems.

In terms of the socio-ecological framework

Our study findings may add to the national strategy on GBV, particularly in IPV among young women. Using the information obtained from this study, interventions to reduce IPV can be developed based on the data and offer opportunities to work with young women attending secondary schools. These can then be implemented and evaluated to determine whether programs that address the protective variables are associated with reductions in IPV rates in young women:

a) At an individual and relationship level

Young women in this study confirmed that they learnt about IPV through their observations and the experiences shared by their peers. The advice of friends and the attitude of mothers were seen as providing guidance and a determining factor in their understanding of IPV. The young women's personal experiences at home and friends' experiences shaped their views and expectations about IPV. This may have a role in the attitudes of acceptance of partner violence in young women.

Since parents are said to have a role in their children's development, it is thus urgent to design programs that emphasize parental involvement and education about IPV (77). Working in collaboration with communities is essential so that parents are sensitized more about gender norms. Seminars with mothers and peers to improve their knowledge on GBV, strengthening their skills to prevent IPV and improving their attitudes on IPV as role models.

Since young women are at a stage where they are initiating relationships, they need to understand the implicit and explicit forms of IPV and the effects on their psychological development. The opportunity to improve young women's awareness about IPV and its psychological, physical and sexual forms of abuse can be undertaken during health promotion activities. These should be included

in the school programs on a) sexual and reproductive health and rights, and b) when addressing the prevention of adolescents' sexual risk behaviours. For effective results, both sexes should be included in these programs (78).

As this study has shown, it is essential to take cognizance of young women in their contextual environment to empower them with the necessary knowledge and skills that can reduce their vulnerability. This requires that young women be introduced to education about GBV, human rights and IPV early in life.

Collaboration between the health and education sectors and other relevant sectors (for example, social work) in designing GBV programs is required to develop the programs that should be introduced in the schools' curricula and extended to families and communities. Such programs are necessary to allow young women to discuss aspects of human, sexual, and reproductive rights and develop the skills to prevent and not accept IPV as normative behavior.

There are promising initiatives that have been implemented in SSA that could be tested in Mozambique. For example, a school-based curriculum program implemented in Kenya aims to increase awareness of gender roles, norms, and violence (78). The program was directed toward male high school students between 15–22 years old. Attitudes of males toward girls and women gender roles and norms improved after the intervention (78). The program could be adapted in Mozambique and include young school-going males and females addressing gender norms to prevent IPV.

A school-based intervention with schoolgirls aged 10-16 years old, of both sexes in Kenya, consisted of a multicomponent curriculum that focused on promoting gender-equitable behavior with the boys and girls, implemented empowerment gender relations, and self-defence training. A reduction in risk of sexual assault was estimated at 3.7 % decrease, $p = 0.03$ and 95 % CI = (0.4, 8.0), among the girls (79). The program is promising to be adapted in the context of Mozambique. It offers the opportunity to introduce gender norms and gender-based violence prevention early in schools.

Economic status has also been an essential factor associated with IPV among young women in this study. There is a need for specific prevention programs to improve the financial circumstances of young women in schools. That will increase the young women's autonomy to leave an abusive relationship and reduce the risk of partner violence.

Economic empowerment programs through skills training for income generation activities for young women in schools and communities would help to reduce their financial vulnerabilities. Intervention

with “Microfinance for AIDS and Gender Equity in South Africa” showed that women with their own income experienced less violence and improved the women’s ability to challenge the acceptance of violence and leave violent relationships (43).

Mozambique is committed to the 2030 targets for sustainable development, and the 2015−2019 and the 2020−2024 Government five-year programs have integrated the strategic objective of gender equality and empowering women and girls (80). There is an indication of an initiative aimed at improving women's economic and financial status in Mozambique, promoting entrepreneurship and employment opportunities, as an element of the 2030 Sustainable Development Agenda (81).

However, the reported “National Program for women’s economic empower” was only launched recently in 2019. It prioritizes illiterate women from rural areas. It is not addressing the needs of school-going young women.

Changing gender norms regarding male dominance requires school-based and community-based initiatives to promote gender equity and economic empowerment that may further enhance communal engagement and information dissemination channels.

The economic vulnerabilities within young women’s families have important political implications and consideration of programs that bolster financial capital within households and communities while integrating cultural beliefs and gender-egalitarian notions.

Another finding from this study was that alcohol consumption might result in IPV due to the reduction in inhibitions and increased propensity to violence, leading to physical and sexual abuse. In Mozambique, alcohol consumption amongst high school learners has been previously reported as a concern and requires immediate attention. It is thus crucial to tackle alcohol use and implement and enforce control programs for alcohol use among young people in and out of school to reduce risky behaviors and IPV (32, 82).

b) At the community level

The study findings suggested that churches may influence IPV perpetration by promoting norms that require females to be submissive to their partners since this endorses beliefs of male superiority in relationships and marriages.

IPV awareness and preventions programs and strategies need to be discussed and implemented, considering the needs of individuals and the community's religious values and the detrimental consequences of IPV on women.

These would require collaboration with community members, leaders and educational sectors in addressing IPV awareness and developing targeted prevention strategies that consider how to protect individuals, despite the community's religious values. Collaboration between churches, health sectors, and organizations working on GBV, targeting males, females, and children to protect human rights and prevent GBV, would help end IPV. There is also a need for regulation of churches and ensuring that churches collaborate in discouraging IPV rather than accepting it (45).

c) At the Societal level

The findings from our study raise a concern about young women's low gender empowerment. IPV is deeply entrenched in cultural practices and decision-making processes where men make all the decisions concerning their relationship and women's sexual and reproductive health.

Cultural practices such as males having multiple partners and the practice of lobola still prevail in their communities and reinforce male superiority against women. The existing socio-cultural vulnerabilities among young women may result from the social context or environment where they are integrated, such as the community where they live, which may endorse strong ideologies of male dominance. Therefore, comprehensive programs need to empower younger women with skills to challenge such harmful norms when implementing IPV and collaborate with the community and the educational sector to change gender norms regarding male dominance.

The community-based intimate partner program implemented in Uganda used an ecological framework to address factors of IPV at the individual, relationship and societal levels. It was working with community residents, local leaders, and professionals to prevent and mitigate gender-based violence. Physical and sexual partner abuse was significantly reduced after participation in the intervention (68).

Although the program has been designed to address the factors at multiple levels and the target on social norms, which also demonstrated reducing IPV, the program focused on adults, not targeting the young people (68). The program approaching the multilevel factors including individual, community, and societal levels is promising to be adapted toward young people in schools in Mozambique.

The Male Norms Initiative (MNI) is an intervention focused on males (15–24 years old). The program combines group education and community engagement to address gender norms, social expectations, and responsibilities (83). The intervention aims to promote the development of equitable gender norms and reduce the risk of adverse health outcomes associated with gender norm behaviors.

Although the program is directed to males, this has been found to produce a statistically significant reduction in violence perpetration, lower risk of HIV and other STIs, which leads to healthier relationships (83). The program is promising to be adapted in another context such as Mozambique to include females working with community leaders to address IPV prevention.

Strengthening male involvement through collaborations with community leaders for peer education activities may improve the opportunity for all stakeholders to discuss the social norms and influence changes in the perception of male dominance. These could include mass media programs involving males discussing themes about the negative consequences of having multiple sexual partners, the perception about the practices of lobola or payment for marriage and the need for males to change attitudes and behaviors regarding the perpetration of IPV.

It is urgent to include law enforcement strategies and programs (including school programs) that stress human rights and disapproval of violence through the communities and social structures to ensure social support for IPV prevention in Mozambique.

Among young women, the autonomy to prevent IPV may be limited if they lack awareness about IPV and knowledge about the supportive services for the victims of IPV.

There is a need to create specific IPV counselling centres for young women to meet their needs and allow the counsellors to screen for other potential sexual and reproductive problems that affect young women in Mozambique.

In Mozambique, as in many other African countries, the services to address IPV are available but are not specifically for young women (62-64). These are mainly based in health care centres in order to promote a multisectoral response to prevent GBV and integrate the sectors of health, social work, justice, and police. The opportunity for those young women in dating or occasional relationships or those initiating relationships and experiencing IPV to seek help may be limited (65).

In a study undertaken to evaluate the available mechanisms in Maputo to obtain assistance, the results indicated several factors influencing the victims against attending such services (84). Participants in that study felt that the providers lacked empathy. They also felt that providers in the different sectors

of the intervention are not confident about dealing with the victims. The professionals delivering this service who were interviewed during the study revealed their lack of training about GBV and the lack of coordination within the sectors about their different roles. These factors influenced their ability to provide and deliver adequate assistance to the victims of IPV (84).

This study, therefore, advocates new approaches with policies and programs to meet young women's needs and to encourage young women to report and obtain appropriate services relating to their sexual and reproductive health, including GBV issues (85).

Since there are services available specifically to address adolescents and young people's sexual and reproductive health, this provides an opportunity that should be grasped to extend the awareness, prevention and support programs to prevent IPV in young women (86). Thus, it is crucial to raise awareness among young women and encourage potential victims to report to the available supporting services for victims of IPV.

Training programs to strengthen the skills of the providers in such services should be prioritized (87). Therefore, concerted and improved awareness campaigns involving communities and advertising the available services would help young women reach the counselling centres and prevent IPV. It is vital to collaborate with local stakeholders in delivering information about IPV and the available services for support in the community.

The use of audiovisual resources, including posters, brochures, social media, radio and television to deliver information about IPV, may help attain access for all population groups and extracts. Non-Governmental Organizations (NGOs) have a key role in delivering awareness campaigns and preparing the communities for early interventions to prevent IPV among young women (27, 66).

There are promising programs in SSA, which can be piloted in Mozambique to improve young women sexual and reproductive health and prevent IPV.

The Steppingstone intervention, which consisted of education in contents regarding sexual health and risk behaviors, contraception, HIV, communication skills, and gender-based violence to both men and women, was initially implemented in Uganda. In South Africa, it has been adapted for adolescents and young adults ages 15–26 and showed promise in decreasing IPV (88).

At 24 months of Steppingstone interventions, fewer men reported IPV perpetration than those in the control group (6% vs 10%, $p = 0.054$) (88).

In Mozambique, the program can be adapted to young adolescents, girls and boys attending schools and to include those out of schools so that they benefit from content regarding sexual and reproductive health, human rights and prevention of GBV.

"SASA", which means now in Kiswahili, is a community mobilization intervention developed to prevent violence and reduce HIV risk behaviors that were started by Raising Voices in Uganda (89). It has also been adapted in Botswana, Burundi, Ethiopia, Kenya, Malawi, Rwanda, South Sudan, Tanzania, Uganda, and Zambia. Evaluation studies have shown reduced attitudes of social acceptance of partner violence and acceptability of the right to refuse sex (89). The intervention was also associated with significant low acceptance of IPV among women and men.

Further, men who participated in the intervention reported a significantly low incidence of concurrent sexual partners in the past year than men who did not participate (0.57, 95% CI [0.36–0.91] (89). In addition, participants in the intervention reported low experience of physical and sexual partner abuse (89).

These programs are promising to be tested in the context of Mozambique to improve young women sexual and reproductive health and knowledge of their right to refuse sex and would.

9.2.2. Further research

The factors associated with the high prevalence of IPV in young women, which emerged in this study, highlight the inadequacies in the current IPV intervention programs, which include the Gender policy and strategy for its implementation (90); The National plan for prevention of GBV (8) and the multisectoral mechanism for GBV (64), in reducing the young women's vulnerabilities and thus prevent IPV.

a) Health sector

These strategies mainly implemented by the health sector aim to prevent IPV through concerted activities that include education of individuals and communities on gender norms, human rights, reproductive health, IPV prevention, and the awareness of the services available for support. The training of health care providers is necessary to assist the victims and to implement the mechanism and the inclusion of GBV in health professionals training curricula (91).

A review is required concerning the existing interventions aiming to reduce IPV, evaluate if they include the risk factors shown in this study among young women, and explore how the best interventions at the individual, community and societal levels can be developed, implemented and evaluated.

b) Educational sector

The current prevention programs on partner violence in Mozambique indicate collaboration with the educational sector to promote gender equality. However, the findings from our study raise a concern about the young women's low gender empowerment attitudes and indicate an urgent need for the inclusion of education on gender equality early in the school programs (61).

There is a need to evaluate how current primary prevention interventions such as the promotion of gender equity and IPV awareness in schools can best be adapted by adding multi-level contextual approaches that reach young women in schools early.

c) Individual, Community and Societal levels

At an individual level, research is required to evaluate whether current interventions on IPV can be adapted to improve young women's understanding of IPV and how this compromises their human rights and their physical, sexual and mental health.

At a community and societal level, research is recommended to investigate if interventions programs can be developed to investigate if improving the individual and communities' skills to challenge the negative social norms would reduce the vulnerabilities of young women and IPV in an urban setting and to evaluate the role of religiosity and its relationship to IPV.

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APPENDICES

1. Appendix A: Ethical approval –Humanities and Social Science Research Ethics Committee, University of KwaZulu-Natal
2. Appendix B: Ethical approval –National Health Bioethics Committee of Mozambique (Portuguese & English)
3. Appendix C: Permission –Educational Directorate of Maputo city
4. Appendix D: Focus Group informed consent form for guardians
5. Appendix E: Focus Group informed consent form for young women above 18 years
6. Appendix F: Focus Group assent form for young women under 18 years
7. Appendix G: Survey informed consent form for guardians
8. Appendix H: Survey informed consent form for young women above 18 years
9. Appendix I: Survey assent form for young women under 18 years
10. Appendix J: Focus Group Discussion Guide (English version)
11. Appendix K: Focus Group Discussion Guide (Portuguese version)
12. Appendix L: Self-administered questionnaire (English version)
13. Appendix M: Self-administered questionnaire (Portuguese version)
14. Appendix N: List of themes, subthemes and codes
15. Appendix O: Sociodemographic characteristic of participants for Focus Group Discussion
16. Appendix P: Sociodemographic characteristic of participants for Survey

Appendix A:

Ethical approval –Humanities and Social Science Research Ethics Committee, University of KwaZulu-Natal

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

16 January 2019

Mrs Maria Suzana B Maguele 218086131
School of Nursing and Public Health
Howard College Campus

Dear Mrs Maguele

Protocol reference number: HSS/2005/018D
Project title: Socio-cultural factors influencing intimate partner violence among young women (15-24 years old) in KaMpfumo Municipal District of Maputo City (Mozambique).

Full Approval – Full Committee Reviewed Application

With regards to your response received 14 January 2019 to our letter of 03 December 2018, the Humanities and Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

Please note: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....
Dr Shamila Naidoo (Deputy Chair)

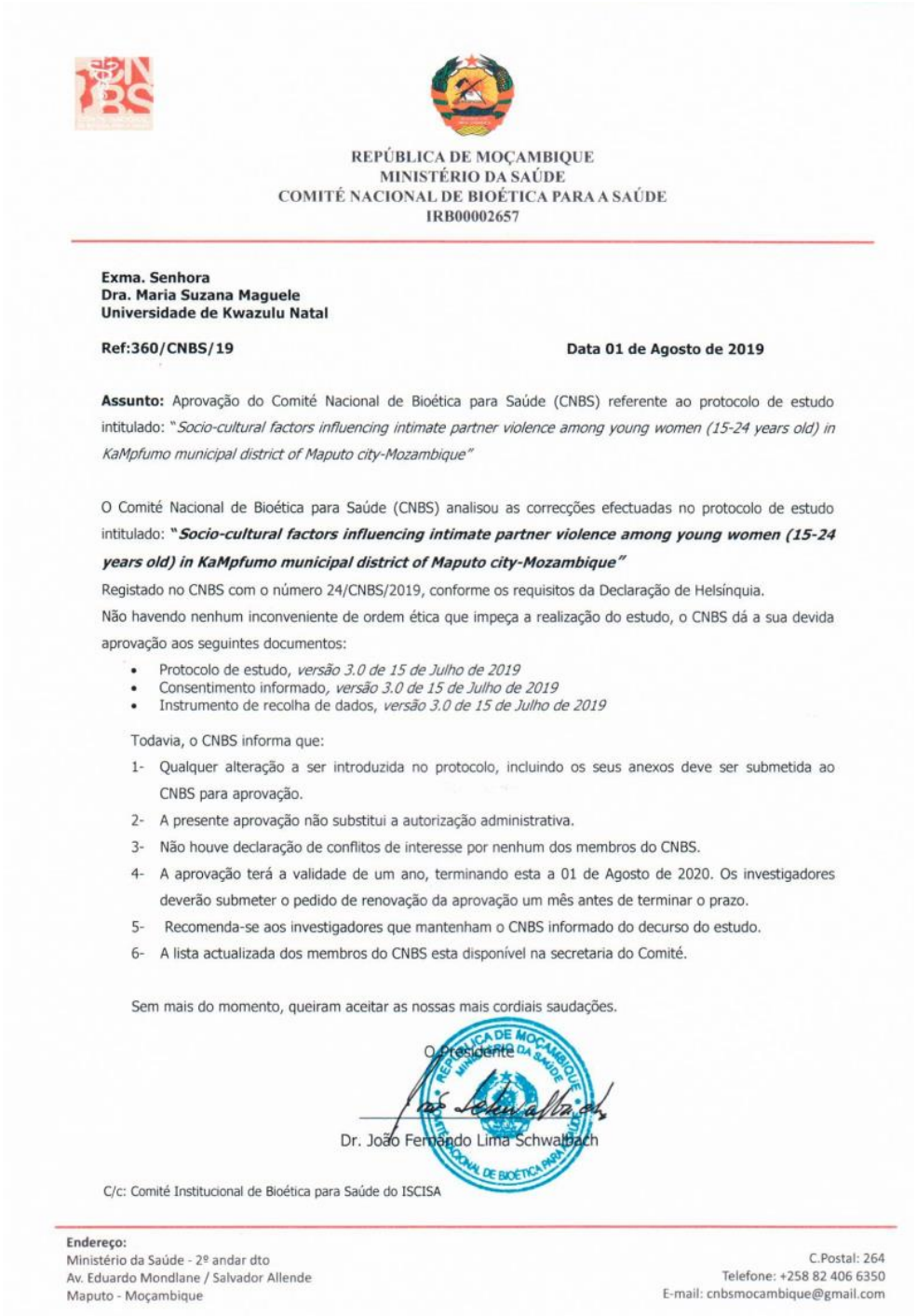
/px

cc Supervisor: Dr N Khuzwayo and Prof M Taylor
cc Academic Leader Research: Dr T Mashamba-Thompson
cc School Administrator: Ms M Ramlall

Humanities & Social Sciences Research Ethics Committee
Dr Rosemary Sibanda (Chair)
Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Telephone: +27 (0) 31 260 3587/8350/4557 **Facsimile:** +27 (0) 31 260 4609 **Email:** ximbap@ukzn.ac.za / snymanm@ukzn.ac.za / mohunp@ukzn.ac.za
Website: www.ukzn.ac.za

Appendix B:

Ethical approval –National Health Bioethics Committee of Mozambique (Portuguese & English)



REPÚBLICA DE MOÇAMBIQUE
MINISTÉRIO DA SAÚDE
COMITÉ NACIONAL DE BIOÉTICA PARA A SAÚDE
IRB00002657

Exma. Senhora
Dra. Maria Suzana Maguele
Universidade de Kwazulu Natal

Ref:360/CNBS/19 **Data 01 de Agosto de 2019**

Assunto: Aprovação do Comité Nacional de Bioética para Saúde (CNBS) referente ao protocolo de estudo intitulado: "*Socio-cultural factors influencing intimate partner violence among young women (15-24 years old) in KaMpfumo municipal district of Maputo city-Mozambique*"

O Comité Nacional de Bioética para Saúde (CNBS) analisou as correcções efectuadas no protocolo de estudo intitulado: "***Socio-cultural factors influencing intimate partner violence among young women (15-24 years old) in KaMpfumo municipal district of Maputo city-Mozambique***"

Registado no CNBS com o número 24/CNBS/2019, conforme os requisitos da Declaração de Helsínquia.

Não havendo nenhum inconveniente de ordem ética que impeça a realização do estudo, o CNBS dá a sua devida aprovação aos seguintes documentos:

- Protocolo de estudo, *versão 3.0 de 15 de Julho de 2019*
- Consentimento informado, *versão 3.0 de 15 de Julho de 2019*
- Instrumento de recolha de dados, *versão 3.0 de 15 de Julho de 2019*

Todavia, o CNBS informa que:

1- Qualquer alteração a ser introduzida no protocolo, incluindo os seus anexos deve ser submetida ao CNBS para aprovação.
2- A presente aprovação não substitui a autorização administrativa.
3- Não houve declaração de conflitos de interesse por nenhum dos membros do CNBS.
4- A aprovação terá a validade de um ano, terminando esta a 01 de Agosto de 2020. Os investigadores deverão submeter o pedido de renovação da aprovação um mês antes de terminar o prazo.
5- Recomenda-se aos investigadores que mantenham o CNBS informado do decurso do estudo.
6- A lista actualizada dos membros do CNBS esta disponível na secretaria do Comité.

Sem mais do momento, queiram aceitar as nossas mais cordiais saudações.

O Presidente

Dr. João Fernando Lima Schwalbach

C/c: Comité Institucional de Bioética para Saúde do ISCISA

Endereço:
Ministério da Saúde - 2º andar dto
Av. Eduardo Mondlane / Salvador Allende
Maputo - Moçambique

C.Postal: 264
Telefone: +258 82 406 6350
E-mail: cnbsmocambique@gmail.com

UNITED TRANSLATORS

CERTIFICADO

Eu, abaixo-assinado, Tradutor Oficial Ajuramentado, devidamente autorizado e ajuramentado pelo Tribunal Judicial da Cidade de Maputo, em nome da UNITED TRANSLATORS, LDA, Entidade Legal nº 101039897, com Licença nº 4160/11/01/2018, certifico que a tradução do **DOCUMENTO** em anexo, de Português para Inglês, a favor do **COMITÉ NACIONAL DE BIOÉTICA PARA A SAÚDE** é verdadeira, correcta e do melhor do meu conhecimento, da qual assumo total responsabilidade.

AFFIDAVIT

I, the undersigned, Official Sworn Translator, dully authorised and sworn by the Maputo City Judicial Court, on behalf of UNITED TRANSLATORS, LDA, Legal Entity no 101039897, Licence no 4160/11/01/2018, hereby certify that the translation of the enclosed **DOCUMENT** from Portuguese into English, in favour of the **NATIONAL COMMITTEE ON BIOETHICS FOR HEALTH** is true, correct and to the best of my knowledge, to which I take full responsibility.

Maputo, 20 de April de 2020 I April 20th, 2020

Celso Mauricio Manhiça
Tradutor/Translator

UNITED TRANSLATORS, LDA
Av. Karl Marx, 799, Maputo
NUIT 400919143

Júlio J. Isaías Munguambe
Director-Geral/General Manager

CELSO MAURÍCIO MANHIÇA
Tradutor Ajuramentado
Português / Inglês / Português
Cel. 822915578 / 845107127
NUIT: 400839832

Reconheço a assinatura de Celso Maurício Manhiça e certifico que o signatário é Tradutor Oficial ajuramentado com poderes suficientes para este acto.
Maputo, 21-04-2020
Reg. N.º 9225 Emol. 100,00
O Conservador Notário Técnico do Primeiro Cartório Notorial de Maputo

CONTA
Art.º 1641 100,00
Art.º 1642 50,00
Art.º
Soma
Selo de Verba
Custo
Despesas
Total 150,00

[*Coat of Arms*]
REPUBLIC OF MOZAMBIQUE
MINISTRY OF HEALTH
NATIONAL COMMITTEE ON BIOETHICS FOR HEALTH
IRB00002657

Dear Madam
Dr. Maria Suzana Maguele
Kwazulo Natal University

Ref. 360/CNBS/19 **Date: August 1, 2019**

RE: Approval of the National Committee on Bioethics for Health relating to the study protocol entitled: "Socio-cultural factors influencing intimate partner violence among young women (15-24 years old) in KaMpfumo Municipal District of Maputo City – Mozambique"

The National Committee on Bioethics for Health (CNBS) has analysed the corrections effected in the study protocol entitled: **"Socio-cultural factors influencing intimate partner violence among young women (15-24 years old) in KaMpfumo Municipal District of Maputo City – Mozambique"**
Registered in the CNBS under no 24/CNBS/2019, as per the requirements of the Helsinki Declaration.
There being no ethical inconveniences that impair the conduction of the study, CNBS hereby grants its approval to the following documents:

- Study protocol, version 3.0 of July 15, 2019
- Informed consent, version 3.0 of July 15, 2019
- Data collection tool, version 3.0 of July 15, 2019

However, CNBS informs that:

1. Any amendment to be inserted in the protocol, including its annexures, should be submitted to CNBS for approval.
2. This approval does not replace the administrative authorisation.
3. There was no declaration of conflict of interest from any CNBS member.
4. The approval is valid for one year, thereby expiring on August 1, 2020. The researchers should submit the approval renewal request one month prior to the expiration date.
5. We recommend researchers to keep CNBS informed on the progress of the study.
6. An updated list of CNBS members is available in the Committee office.

Warm regards

[*Signed*]
Dr. Joao Fernando Lima Schwalbavh
Committee Chairperson

C/C: ISCISA Institutional Committee on Bioethics for Health

4373

4374

Appendix C:

Permission –Educational Directorate of Maputo city

REPUBLIC OF MOZAMBIQUE

Government of Maputo City

DIRECTORATE OF EDUCATION AND HUMAN DEVELOPMENT

DEPARTMENT OF NUTRITION AND SCHOOL HEALTH

CREDENTIAL

The Directorate of Education and Human Development of Maputo City accredits **Maria Suzana Bata Maguele** to carry out a research at the Secondary schools of Maputo City, in the Municipality District of KaMphumu, for the purpose of attaining her Doctoral Degee.

However, such a research must be coordinated with the District and Schools' Directorates and it must not interfere with the normal course of the School Year Activities.

NB: The findings must be shared with the Directorate of Education and Human Development of Maputo City, before their official publication.

Maputo, May 15, 2018

Director

Artur Armando Dombo

(Senior Teacher)

Appendix D:

INFORMED CONSENT AND CONSENT FOR FOCUS GROUP DISCUSSIONS

Parents/guardians of participants between 15-17 years old

Title: Socio-cultural factors influencing Intimate partner violence among young women in KaMpfumo municipal district- Maputo City

Information Sheet and Consent to Participate in Research

Date:

Hello, thank you for allowing me to speak to you.

My name is Maria Suzana Bata Maguele. I am a student of the PhD program at the University of Kwazulu Natal, and I am also a lecturer at Instituto Superior de Ciências de Saúde, in Maputo. My contact cell phone is +258 844886772/+27606320238 and e-mail address: suzybata@gmail.com. I am conductingresearch entitled: Socio-cultural factors influencing Intimate partner violence among young women in KaMpfumo municipal district- Maputo City". The study is part of my PhD studies.

You are being asked to consider allowing your child to participate in a research study that involves young women's health, beliefs, knowledge, perspectives and experiences about intimate partner violence against women. The aim and purpose of this research are to investigate sociocultural factors that influence IPV among young women.

The study is expected to enrol in total, 40 young women aged 15-24. The study will be conducted in 3 Complete Secondary Schools from KaMpfumo municipal district, in each of the school we expect to select 15 participants. It will involve focus group discussions of topics related to knowledge, perceptions, believes, perspectives and experiences about intimate partner violence against women. Your child is considered as a possible participant in this study because she/he attends school at one of the study schools. If you decide to allow your child to participate, your child will be requested to participate in group discussions which will be conducted at the school through a focus group discussion guide which contains topics to be verbally explored within a group of 8-10 participants. Efforts to make homogeneous age group will be made. The duration of their participation, if you allow them to enrol and remain in the study, is expected to be once for one hour.

During the focus group discussions as the research will address sensitive issues, some things during the study may trigger negative memories. If he/she could advise me, I will follow up with him/her and refer to the proper health services which are available at no cost.

The study will not provide direct benefits to the participants, but participants can benefit by gathering useful information about IPV. From the findings of the research, they could provide beneficial information for the community, policymakers and research community on the evidence base of the current situation of young women in Maputo City and as well of what is still needed by young women to improve their relationships and prevent IPV.

Participants will be informed about the results of the study by providing a hard copy of it in each school and providing links of publications sites when it is published.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number_____).

In the event of any problems or concerns/questions, you may contact the researcher at Instituto Superior de Ciências de Saúde, Av. Tomas Nduda 977, Maputo. Contact: +258843002817. Personal contact: +258 844886772/+27606320238; e-mail address: suzybata@gmail.com or the UKZN Humanities andand Social Sciences Research Ethics Committee, contact details as follows:

HUMANITIES and and SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001 Durban 4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557- Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

The participation in this research is voluntary and that your child may withdraw participation at any point. Your child participation will not incur any costs. There is no compensation for your child participation. In the event of refusal/withdrawal of participation, your child will not incur a penalty. Neither the benefit of having information about Intimate partner violence to itself. Your child doesn't need to ask permission to withdrawal participation if your child feel don't want to participate or don't

want to continue to stop and withdrawal. Also, your child can skip questions don't feel comfortable to answer.

There are no circumstances that I terminate your child participating unless you or your child withdrawal your consent and assent. Your child's information will then not be used in this study.

All information that your child provided in this discussion will be kept anonymous by removing each subject 's name or any other identifying subject and will be kept strictly confidential. No identifying data will be published.

To protect against the risk of loss of confidentiality, data will be kept confidential by being identified only with the subject 's unique ID.

The data collected will be categorized into two: the soft and hard copy. The soft copy will be coded, and a password will be put on it, which will be accessible to supervisors and the principal researcher only. The hard copy will be properly packaged and kept in storage with the principal researcher, securely locked in a cabinet. After five years, it will be shredded and sent to the final disposal site for the destruction of official documents.

CONSENT

I (Name) _____have been informed about the study entitled Socio cultural factors influencing Intimate partner violence among young women in KaMpfumo municipal district- Maputo City) by Maria Suzana Bata Maguele.

I understand the purpose and procedures of the study, which is to investigate sociocultural factors that influence IPV against young women. The study is expected to enrol 40 young women aged 15-24 in total. The study will be conducted in 3 Complete Secondary Schools from KaMpfumo municipal district, in each of school, the study expects to select (15) participants. It will involve focus group discussions accessing topics related to knowledge, perceptions, believes, perspectives and experiences about intimate partner violence against women, through focus group discussion guide

which contains open topics to be verbally discussed within 6-8 participants in each focus group discussion.

I have been allowed to answer questions about the study and have had answers to my satisfaction.

I declare that my child participates in this study is entirely voluntary and that my child may withdraw at any time without affecting any of the benefits that my child usually is entitled to.

If I have any further questions/concerns or queries related to the study, I understand that I may contact the researcher at Instituto Superior de Ciências de Saúde, Av. Tomas Nduda 977, Maputo. Contact: +258843002817. Personal contact: +258 844886772/+27606320238; e-mail address: suzybata@gmail.com

If I have any questions or concerns about my child's rights as a study participant, or if I am concerned about an aspect of the study or the researchers, then I may contact:

HUMANITIES and SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

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Govan Mbeki Building

Private Bag X 54001Durban 4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557 - Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

Additionally, I hereby provide consent to:

Audio-record interview / focus group discussion YES / NO

_____ _____

Signature of Parent/guardian **Date**

_____ _____

Signature of Witness **Date**

Appendix E

INFORMED CONSENT AND CONSENT FOR FOCUS GROUP DISCUSSIONS

Participants between the ages of 18-24 years

Title: Socio-cultural factors influencing Intimate partner violence among young women in KaMpfumo municipal district- Maputo City

Participant information sheet and consent to participate in Research

Date:

Hello, thank you for allowing me to speak to you.

My name is Maria Suzana Bata Maguele. I am Student of PhD program at the University of Kwazulu Natal, and I am also a lecturer at Instituto Superior de Ciências de Saúde, in Maputo. My contact cell phone is +258 844886772/+27606320238 and e-mail address: suzybata@gmail.com. I am conductingresearch entitled: Socio-cultural factors influencing Intimate partner violence among young women in KaMpfumo municipal district- Maputo City". The study is part of my PhD studies.

You are being invited to consider participating in a study that involves research about young women's health, believes, knowledge, perspectives and experiences about intimate partner violence against women. The aim and purpose of this research are to investigate sociocultural factors that influence IPV against young women. The study is expected to enroll in total (40) young women aged 15-24. The study will be conducted in 3 Complete Secondary Schools from Kamphumo Municipal District, in each of school, we expect to select (15) participants. It will involve focus group discussions of topics related to knowledge, perceptions, believes, perspectives and experiences about intimate partner violence against women. The focus group discussion will be conducted through focus group discussions guide within a group of 8-10 participants, which contain open question where is expected your opinion, feelings and perspectives about IPV. The duration of your participation, if you choose to enroll and remain in the study, is expected to be one hour.

During focus group discussion, personal experiences of IPV will not be asked. However, the study may involve potential risk regarding emotional distress, as the research will abroad sensitive issues, it may happen that you hear or share some things during the focus group discussions that trigger your negative memories. If you become distressed, please advise me. I will follow up with you to discuss

your emotions and assess the need to refer you to the property services. Available Integrated Services to attend women victims of intimate partner violence are also providing psychological assistance for issues regarding intimate partner violence. The services are available, and no cost to be attended. The services provide integrated assistance, as psychological, police and clinic. Additional information regarding services can be obtained in public health centres.

The study will not provide direct benefits to the participants; otherwise, participants can benefit gathering useful information regarding IPV for them, also for other women with who will share information. From the findings of the research, they could provide beneficial information for the community, policymakers and research community on the evidence base of the current situation of young women in Maputo City and about what is still need among young women to improve their relationships and prevent IPV.

Participants will be informed about the results of the study by providing a hard copy of it in each school and providing links of publications sites when it is published.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number_____).

In the event of any problems or concerns/questions, you may contact the researcher at Instituto Superior de Ciências de Saúde, Av. Tomas Nduda 977, Maputo. Contact: +258843002817. Personal contact: +258 844886772/+27606320238; e-mail address: suzybata@gmail.com or the UKZN Humanities and Social Sciences Research Ethics Committee, contact details as follows:

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Tel: 27 31 2604557- Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

Your participation in this research is voluntary and that you may withdraw participation at any point. Your participation will not incur any costs, what you should dispense is your time and your

contributions ideas in the discussion. There is no compensation for your participating. In the event of refusal/withdrawal of participation, you will not incur a penalty. Neither the benefit of having information about Intimate partner violence to yourself. You don't need to ask permission to withdrawal participation if you feel you don't want to participate or you don't want to continue your stop and withdrawal. Also, you can skip questions you don't feel comfortable to answer.

There are no circumstances that I terminate your participating unless is your intent to.

All information that you provide in this discussion will be kept anonym by removing each subject 's name or any other identifying subject and will be kept strictly confidential. No identifying data will be published.

To protect against the risk of loss of confidentiality, data will be kept confidential by being identified only with the subject 's unique identification number.

The data collected will be categorized into two: the soft and hard copy. The soft copy will be coded, and a password will be put on it, which will be accessible to supervisors and the principal researcher only. The hard copy will be properly packaged and kept in storage with the principal researcher, securely locked in a cabinet. After five years, it will be shredded and sent to the final disposal site for the destruction of official documents.

CONSENT

I (Name) _____have been informed about the study entitled Socio-cultural factors influencing Intimate partner violence among young women in KaMpfumo municipal district- Maputo City) by Maria Suzana Bata Maguele.

I understand the purpose and procedures of the study, which is to investigate sociocultural factors that influence IPV against young women. The study is expected to enrol (424) young women aged 15-24 in total. The study will be conducted in 3 Complete Secondary Schools from KaMpfumo municipal district, in each of school, the study expects to select (150) participants. It will involve focus group discussion within 8-10 participants in each group, accessing topics related to knowledge, perceptions, believes, perspectives and experiences about intimate partner violence against women, through focus group discussion guide.

I have been allowed to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any of the benefits that I usually am entitled to.

If I have any further questions/concerns or queries related to the study, I understand that I may contact the researcher at Instituto Superior de Ciências de Saúde, Av. Tomas Nduda 977, Maputo. Contact: +258843002817. Personal contact: +258 844886772/+27606320238; e-mail address: suzybata@gmail.com

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers, then I may contact:

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Private Bag X 54001 Durban 4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557 - Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

Additionally, I hereby provide consent to:

Audio-record my interview / focus group discussion YES / NO

_____ _____

Signature of Participant **Date**

_____ _____

Signature of Witness **Date**

(Where applicable)

_____ _____

Appendix F

INFORMED CONSENT AND ASSENT FOR FOCUS GROUP DISCUSSIONS

Participants between ages of 15-17 years

Title: Socio cultural factors influencing Intimate partner violence among young women in KaMpfumo municipal district- Maputo City

Participant information sheet and consent to participate in Research

Date:

Hello, thank you for giving me an opportunity to speak to you.

My name is Maria Suzana Bata Maguele. I am Student of PhD program at the University of Kwazulu Natal, and I am also a lecturer at Instituto Superior de Ciências de Saúde, in Maputo. My contact cell phone is +258 844886772/+27606320238 and e-mail address: suzybata@gmail.com. I am conducting a research entitled: Socio-cultural factors influencing Intimate partner violence among young women in KaMpfumo municipal district- Maputo City". The study is part of my PhD studies.

You are being invited to consider participating in a study that involves research about young women's health, believes, knowledge, perspectives and experiences about intimate partner violence against women. The aim and purpose of this research are to investigate sociocultural factors that influence IPV against young women. The study is expected to enrol in total (40) young women aged 15-24. The study will be conducted in 3 Complete Secondary Schools from Kamphumo Municipal District, in each of school, we expect to select (15) participants. It will involve focus group discussions of topics related to knowledge, perceptions, believes, perspectives and experiences about intimate partner violence against women. The focus group discussion will be conducted through focus group discussions guide within a group of 8-10 participants, which contain open question where is expected your opinion, feelings and perspectives about IPV. The duration of your participation, if you choose to enrol and remain in the study, is expected to be one hour.

During focus group discussion, personal experiences of IPV will not be asked although, the study may involve potential risk regarding emotional distress, as the research will abroad sensitive issues, you may hear or share some things during the focus group discussions that trigger your negative memories. If you become distressed, please advise me. I will follow up with you to discuss your

emotions and assess the need to refer you to the property services. Available Integrated Services to attend women victims of intimate partner violence are also providing psychological assistance for issues regarding intimate partner violence. The services are available, and no cost to be attended. The services provide integrated assistance, as psychological, police and clinic. Additional information regarding services can be obtained in public health centres.

The study will not provide direct benefits to the participants; otherwise, participants can benefit gathering useful information regarding IPV for them, also for other women with who will share information. From the findings of the research, they could provide beneficial information for the community, policymakers and research community on the evidence base of the current situation of young women in Maputo City and about what is still need among young women to improve their relationships and prevent IPV.

Participants will be informed about the results of the study by providing a hard copy of it in each school and providing links of publications sites when it is published.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number_____).

In the event of any problems or concerns/questions, you may contact the researcher at Instituto Superior de Ciências de Saúde, Av. Tomas Nduda 977, Maputo. Contact: +258843002817. Personal contact: +258 844886772/+27606320238; e-mail address: suzybata@gmail.com or the UKZN Humanities and Social Sciences Research Ethics Committee, contact details as follows:

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Private Bag X 54001 Durban 4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557- Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

Your participation in this research is voluntary and that you may withdraw participation at any point. Your participation will not incur any costs, what you should dispense is your time and your

contributions ideas in the discussion. There is no compensation for your participating. In the event of refusal/withdrawal of participation, you will not incur a penalty. Neither the benefit of having information about Intimate partner violence to yourself. You don't need to ask permission to withdrawal participation if you feel you don't want to participate or you don't want to continue your stop and withdrawal. Also, you can skip questions you don't feel comfortable to answer.

There are no circumstances that I terminate your participating unless is your intent to.

All information that you provide in this discussion will be kept anonym by removing each subject 's name or any other identifying subject and will be kept strictly confidential. No identifying data will be published.

To protect against the risk of loss of confidentiality, data will be kept confidential by being identified only with the subject 's unique ID.

The data collected will be categorized into two: the soft and hard copy. The soft copy will be coded, and a password will be put on it, which will be accessible to supervisors and the principal researcher only. The hard copy will be properly packaged and kept in storage with the principal researcher, securely locked in a cabinet. After five years, it will be shredded and sent to the final disposal site for the destruction of official documents.

PARTICIPANT ASSENT

My parent/ guardian has signed a consent form for my participation in the study.

I (Name) _____have been informed about the study entitled Socio cultural factors influencing Intimate partner violence among young women in KaMpfumo municipal district- Maputo City) by Maria Suzana Bata Maguele.

I understand the purpose and procedures of the study, which is to investigate sociocultural factors that influence IPV against young women. The study is expected to enrol (424) young women aged 15-24 in total. The study will be conducted in 3 Complete Secondary Schools from KaMpfumo municipal district, in each of school, the study expects to select (150) participants. It will involve focus group discussion within 8-10 participants in each group, accessing topics related to knowledge, perceptions,

believes, perspectives and experiences about intimate partner violence against women, through focus group discussion guide.

I have been allowed to answer questions about the study and have had answers to my satisfaction. I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any of the benefits that I usually am entitled to.

If I have any further questions/concerns or queries related to the study, I understand that I may contact the researcher at Instituto Superior de Ciências de Saúde, Av. Tomas Nduda 977, Maputo. Contact: +258843002817. Personal contact: +258 844886772/+27606320238; e-mail address: suzybata@gmail.com

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers, then I may contact:

HUMANITIES andand SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001 Durban 4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557 - Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

Additionally, my parent/guardian provides consent and I myself, assent to:

Audio-record my interview/focus group discussion YES / NO

_____ _____

Signature of Participant **Date**

_____ _____

Signature of Witness **Date**

(Where applicable)

Appendix G

INFORMED CONSENT AND CONSENT FOR SELF ADMINISTERED QUESTIONNAIRE

Parents/guardians of participants between 15-17 years old

Title: Socio cultural factors influencing Intimate partner violence among young women in KaMpfumo municipal district- Maputo City

Information Sheet and Consent to Participate in Research

Date:

Hello. Thank you for giving me an opportunity to speak to you.

My name is Maria Suzana Bata Maguele. I am a student of the PhD program at the University of Kwazulu Natal, and I am also a lecturer at Instituto Superior de Ciências de Saúde, in Maputo. My contact cell phone is +258 844886772/+27606320238 and e-mail address: suzybata@gmail.com. I am conductingresearch entitled: Socio-cultural factors influencing Intimate partner violence among young women in KaMpfumo municipal district- Maputo City". The study is part of my PhD studies.

You are being asked to consider allowing your child to participate in a research study that involves young women's health, beliefs, knowledge, perspectives and experiences about intimate partner violence against women. The aim and purpose of this research are to investigate sociocultural factors that influence IPV among young women.

The study is expected to enroll in total, 424 young women aged 15-24. The study will be conducted in 3 Complete Secondary Schools from KaMpfumo municipal district, in each of the school we expect to select 150 participants. It will involve survey accessing topics related to knowledge, perceptions, believes, perspectives and experiences about intimate partner violence against women. Your child is considered as a possible participant in this study because she/he attends school at one of the study schools. If you decide to allow your child to participate, your child will be requested to feel a self-administered questionnaire which contains ended question to be marked. The duration of their participation, if you allow them to enroll and remain in the study, is expected to be once for 30 minutes.

During the survey, as the research will address sensitive issues, some things during the study may trigger negative memories. If he/she could advise me, I will follow up with him/her and refer to the proper health services which are available at no cost.

The study will not provide direct benefits to the participants, but participants can benefit by gathering useful information about IPV. From the findings of the research, they could provide beneficial information for the community, policymakers and research community on the evidence base of the current situation of young women in Maputo City and as well of what is still needed by young women to improve their relationships and prevent IPV.

Participants will be informed about the results of the study by providing a hard copy of it in each school and providing links of publications sites when it is published.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number_____).

In the event of any problems or concerns/questions, you may contact the researcher at Instituto Superior de Ciências de Saúde, Av. Tomas Nduda 977, Maputo. Contact: +258843002817. Personal contact: +258 844886772/+27606320238; e-mail address: suzybata@gmail.com or the UKZN Humanities and Social Sciences Research Ethics Committee, contact details as follows:

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Private Bag X 54001 Durban 4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557- Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

The participation in this research is voluntary and that your child may withdraw participation at any point. Your child participation will not incur any costs. There is no compensation for your child participation. In the event of refusal/withdrawal of participation, your child will not incur a penalty. Neither the benefit of having information about Intimate partner violence to itself. Your child doesn't need to ask permission to withdrawal participation if your child feel don't want to participate or don't

want to continue to stop and withdrawal. Also, your child can skip questions don't feel comfortable to answer.

There are no circumstances that I terminate your child participating unless you or your child withdrawal your consent and assent. Your child's information will then not be used in this study.

All information that your child provided in this discussion will be kept anonymous by removing each subject 's name or any other identifying subject and will be kept strictly confidential. No identifying data will be published.

To protect against the risk of loss of confidentiality, data will be kept confidential by being identified only with the subject 's unique ID.

The data collected will be categorized into two: the soft and hard copy. The soft copy will be coded, and a password will be put on it, which will be accessible to supervisors and the principal researcher only. The hard copy will be properly packaged and kept in storage with the principal researcher, securely locked in a cabinet. After five years, it will be shredded and sent to the final disposal site for the destruction of official documents.

CONSENT

I (Name) _____have been informed about the study entitled Socio-cultural factors influencing Intimate partner violence among young women in KaMpfumo municipal district- Maputo City) by Maria Suzana Bata Manuele.

I understand the purpose and procedures of the study, which is to investigate sociocultural factors that influence IPV against young women. The study is expected to enrol (424) young women aged 15-24 in total. The study will be conducted in 3 Complete Secondary Schools from KaMpfumo municipal district, in each of school, the study expects to select (150) participants. It will involve survey accessing topics related to knowledge, perceptions, believes, perspectives and experiences about

intimate partner violence against women, through a self-administered questionnaire. I have been allowed to answer questions about the study and have had answers to my satisfaction.

I declare that my child participate in this study is entirely voluntary and that my child may withdraw at any time without affecting any of the benefits that my child usually is entitled to.

If I have any further questions/concerns or queries related to the study, I understand that I may contact the researcher at Instituto Superior de Ciências de Saúde, Av. Tomas Nduda 977, Maputo. Contact: +258843002817. Personal contact: +258 844886772/+27606320238; e-mail address: suzybata@gmail.com

If I have any questions or concerns about my child's rights as a study participant, or if I am concerned about an aspect of the study or the researchers, then I may contact:

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Email: HSSREC@ukzn.ac.za

_____ _____

Signature of Parent/guardian **Date**

_____ _____

Signature of Witness **Date**

(Where applicable)

_____ _____

Signature of Translator **Date**

(Where applicable)

Appendix H

INFORMED CONSENT AND CONSENT FOR SELF ADMINISTERED QUESTIONNAIRE

Participants between the ages of 18-24 years

Title: Socio-cultural factors influencing Intimate partner violence among young women in KaMpfumo municipal district- Maputo city

Participant information sheet and consent to participate in Research

Date:

Hello, thank you for allowing me to speak to you.

My name is Maria Suzana Bata Manuele. I am Student of PhD program at the University of Kwazulu Natal, and I am also a lecturer at Instituto Superior de Ciências de Saúde, in Maputo. My contact cell phone is +258 844886772/+27606320238 and e-mail address: suzybata@gmail.com. I am conducting a research entitled: Socio-cultural factors influencing Intimate partner violence among young women in KaMpfumo municipality district- Maputo City". The study is part of my PhD studies.

You are being invited to consider participating in a study that involves research about young women's health, believes, knowledge, perspectives and experiences about intimate partner violence against women. The aim and purpose of this research are to investigate sociocultural factors that influence IPV against young women. The study is expected to enrol in total (424) young women aged 15-24. The study will be conducted in 3 Complete Secondary Schools from Kamphumo Municipal District, in each of school, we expect to select (150) participants. It will involve survey accessing topics related to knowledge, perceptions, believes, perspectives and experiences about intimate partner violence against women. The survey will be conducted through a self-administered questionnaire which contains ended question where is expected you to feel in according to your opinion/experience. The duration of your participation, if you choose to enrol and remain in the study, is expected to be 30 minutes.

During Survey, experiences of IPV will be asked and that, the study may involve potential risk regarding emotional distress, as the research will abroad sensitive issues, it may happen that you hear or share some things during the questionnaire that trigger your negative memories. If you become distressed, please advise me. I will follow up with you to discuss your emotions and assess the need

to refer you to the property services. Available Integrated Services to attend women victims of intimate partner violence are also providing psychological assistance for issues regarding intimate partner violence. The services are available, and no cost to be attended. The services provide integrated assistance, as psychological, police and clinic. Additional information regarding services can be obtained in public health centres.

The study will not provide direct benefits to the participants; otherwise, participants can benefit gathering useful information regarding IPV for them, also for other women with who will share information. From the findings of the research, they could provide beneficial information for the community, policymakers and research community on the evidence base of the current situation of young women in Maputo City and about what is still need among young women to improve their relationships and prevent IPV.

Participants will be informed about the results of the study by providing a hard copy of it in each school and providing links of publications sites when it is published.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number_____).

In the event of any problems or concerns/questions, you may contact the researcher at Instituto Superior de Ciências de Saúde, Av. Tomas Nduda 977, Maputo. Contact: +258843002817. Personal contact: +258 844886772/+27606320238; e-mail address: suzybata@gmail.com or the UKZN Humanities and Social Sciences Research Ethics Committee, contact details as follows:

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contributions ideas in the discussion. There is no compensation for your participating. In the event of refusal/withdrawal of participation, you will not incur a penalty. Neither the benefit of having information about Intimate partner violence to yourself. You don't need to ask permission to withdrawal participation if you feel you don't want to participate or you don't want to continue your stop and withdrawal. Also, you can skip questions you don't feel comfortable to answer.

There are no circumstances that I terminate your participating unless is your intent to.

All information that you provide in this discussion will be kept anonym by removing each subject 's name or any other identifying subject and will be kept strictly confidential. No identifying data will be published.

To protect against the risk of loss of confidentiality, data will be kept confidential by being identified only with the subject 's unique ID.

The data collected will be categorized into two: the soft and hard copy. The soft copy will be coded, and a password will be put on it, which will be accessible to supervisors and the principal researcher only. The hard copy will be properly packaged and kept in storage with the principal researcher, securely locked in a cabinet. After five years, it will be shredded and sent to the final disposal site for the destruction of official documents.

CONSENT

I (Name) _____have been informed about the study entitled Socio-cultural factors influencing Intimate partner violence among young women in KaMpfumo municipal district- Maputo City) by Maria Suzana Bata Maguele.

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intimate partner violence against women, through a self-administered questionnaire. I have been allowed to answer questions about the study and have had answers to my satisfaction.

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Tel: 27 31 2604557 - Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

_____ _____

Signature of Participant **Date**

_____ _____

Signature of Witness **Date**

(Where applicable)

_____ _____

Signature of Translator **Date**

(Where applicable)

Appendix I

INFORMED CONSENT AND ASSENT FOR SELF ADMINISTERED QUESTIONNAIRE

participant between the ages of 15-17 years

Title: Socio-cultural factors influencing Intimate partner violence among young women in KaMpfumo municipality district- Maputo City

Participant information sheet and consent to participate in Research

Date:

Hello, thank you for allowing me to speak to you.

My name is Maria Suzana Bata Maguele. I am Student of PhD program at the University of Kwazulu Natal, and I am also a lecturer at Instituto Superior de Ciências de Saúde, in Maputo. My contact cell phone is +258 844886772/+27606320238 and e-mail address: suzybata@gmail.com. I am conductingresearch entitled: Socio-cultural factors influencing Intimate partner violence among young women in KaMpfumo municipal district- Maputo City". The study is part of my PhD studies.

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During Survey, experiences of IPV will be asked and that, the study may involve potential risk regarding emotional distress, as the research will abroad sensitive issues, it may happen that you hear or share some things during the questionnaire that trigger your negative memories. If you become distressed, please advise me. I will follow up with you to discuss your emotions and assess the need

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The data collected will be categorized into two: the soft and hard copy. The soft copy will be coded, and a password will be put on it, which will be accessible to supervisors and the principal researcher only. The hard copy will be properly packaged and kept in storage with the principal researcher, securely locked in a cabinet. After five years, it will be shredded and sent to the final disposal site for the destruction of official documents.

PARTICIPANT ASSENT

My parent/ guardian has signed a consent form for my participation in the study.

I (Name) _____have been informed about the study entitled Socio cultural factors influencing Intimate partner violence among young women in KaMpfumo municipal district- Maputo City) by Maria Suzana Bata Maguele.

I understand the purpose and procedures of the study, which is to investigate sociocultural factors that influence IPV against young women. The study is expected to enrol (424) young women aged 15-24 in total. The study will be conducted in 3 Complete Secondary Schools from KaMpfumo municipal district, in each of school, the study expects to select (150) participants. It will involve survey accessing topics related to knowledge, perceptions, believes, perspectives and experiences about

intimate partner violence against women, through a self-administered questionnaire. I have been allowed to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any of the benefits that I usually am entitled to.

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If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers, then I may contact:

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Email: HSSREC@ukzn.ac.za

_____ _____

Signature of Participant **Date**

_____ _____

Signature of Witness **Date**

(Where applicable)

_____ _____

Signature of Translator **Date**

(Where applicable)

Appendix J

Focus Group Discussions-guide (English version)

Title: Socio-cultural factors influencing intimate partner violence among young women (15-24 years old) in KaMpfumo municipal district- Maputo city (Mozambique)

I. General information

Kampfumo municipal district
Name of School_____
FGD-Guide No._____ FGD gender: Female___ Ages_____
Date _____/_____/_____
Nome of interviewer_____
Name of assistants: 1_____2_____

II Topics

1. **What do you know about IPV?**

Probe:

1. Have you ever heard about IPV?
2. Can you tell me when and where the first time have you heard about IPV?
3. Tell me more what you heard about IPV.
4. Please can you describe in your point of view what IPV is?

2.**Whatare your Feelings related to IPV**

Probe:

5. Is the IPV happen in your community? Tell me more about how IPV occurs in your community.
6. Have you ever come across with people abusing each other? Are these people close to you? Can you talk more about this? At the time, what did you think about what you have seen/heard?
7. How do you feel when you heard that some woman had been a victim of IPV?
8. In your opinion, what do you think is the causes of IPV? Tell more about your thoughts about the role of culture/society in IPV? Which factors do you consider influencing more the acceptance of IPV among young women?
9. Tell me what you think about reasons for women to be violented by their partners.

3.**What makes women accept IPV?**

Probe:

10. How do you see IPV, from your point of view, do you think is acceptable? Tell me more about what makes young women accept IPV.
11. If you ever be a victim of IPV, what would you do? Would you tell someone about your problem? Would you look for help/support?
12. How/what Would you talk/ advice people about IPV.
13. In your opinion, what should be done to prevent IPV in Community/society/ relationships?

End of discussion
Thank you so much for your time
Would you like to ask any question or to add some information?

Appendix K

Guião de Discussão de Grupos Focais (versão Português)

Título: Factores socio-culturais que influenciam a violência pelo parceiro intimo em mulheres jovens (15-24 anos de idade) no Distrito Municipal KaMpfumo na Cidade de Maputo (Moçambique)

II. Informação geral

Área de estudo: Distrito municipal KaMpfumo Nome da escola_____ Guião de discussão focal No._____ idades _____ Data da entrevista_____/_____/_____ Nome do entrevistador_____ Nomes dos assistentes: 1_____2_____

II Tópicos de discussão

1. **O que sabes sobre Violência pelo Parceiro Intimo (VPI)?**

Sonda:

2. Alguma vez ouviste falar sobre?
3. Podes falar-me quando e onde ouviste falar de VPI pela primeira vez?
4. Diz me mais sobre o que ouviste sobre VPI.
5. Por favor podes descrever no seu ponto de vista o que é VPI?

2.**Quais são os seus sentimentos sobre a questão da VPI?**

sonda:

6. A VPI tem acontecido na tua comunida? Fala-me mais sobre como a VPI tem ocorrido na tua comunidadede.
7. Já alfuma vez deparaste com alguem que tenha sofrido VPI? Conte mais sobre isso. É alguem proximo de ti? Nesse intante o que te ocorreu sobre o o acontecido?
8. Como descreves os teus sentimentos quando ouves que alguem sofre de VPI?
9. Na tua opinião, quais são as acausas da VPI? Fala mais sobre a tua opinião em relação ao papel das crenças culturais e normas sociais na influência da VPI.
10. Podes dizer o que pensas sobre as razões que levam as mulheres jovens à VPI?

3.**O que faz as mulheres aceitarem VPI?**

Sonda:

11. Como voce vê a questão da VPI? No teu ponto de vista, achas que a VPI é aceitavel em algumas circunstâncias? Podes dizer-me mais sobre o que pode fazer com que mulheres jovens aceitem a VPI?
12. Se alguma vez passasses fosses vitima de VPI como enfretarias a situação?Irias partilhar com alguem sobre a sua experiencia? Como voce acha que poderia resolver? Procuraria ajuda de profissionais?
13. Como e o que poderias ajudar ou aconselhar as pessoas sobre as questões de VPI?
14. O que pensas que e necessario fazer para prevenir a VPI na comunidade e nos relacionamentos?

Fim da discussão

Muito Obrigada pelo seu tempo

Voce gostaria de acrescentar alguma informação ou colocar alguma questão?

Voce gostaria de comentar sobre o que achou da sessão de discussão?

Appendix L

Self-administered questionnaire (English version)

Survey to assess prevalence and factors associated with IPV among young women attending in secondary schools in KaMpfumo municipality district, Maputo- Mozambique.

The questionnaire used in this study to estimate the IPV and associated factors was adapted from the WHO Multi-country Survey of Women's Health and Domestic Violence against Women (Garcia-Moreno, 2005). The WHO Multi-country tools are recommended since they cover issues of IPV, and their validity and reliability have been confirmed. The questionnaire's validity in the Portuguese language was confirmed in the study done in Brazil in two different social contexts (urban and rural). The results indicated the adequacy of the instrument in estimating the occurrence of IPV and the associated factors. The study reported a Cronbach alpha coefficient of 0.88. Thus, the instrument has been shown to be reliable, consistent and adequate to be used in other similar studies accessing IPV, in different contexts such as this study (Schraiber at al., 2010). The IPV was measured both across the lifetime and in the 12 months prior to conduct the survey. The questionnaire was translated from English to Portuguese and back translated into English by a second translator to ensure consistency. The selection of the questions was designed to address the sociocultural context of the young women attending secondary schools in Maputo, based on the information from the focus groups.

The questionnaire was piloted in a school with a similar setting, but not included in the study, amongst 42 young women (10%), to ensure clarity of the questions and consistency in the methods of questioning and the data collection procedure. After the pilot, some issues relating to demographic information were re-formulated for the school-going population in an urban setting in Maputo. The independent variables were divided into two sections. Section one comprised socio-demographic characteristics measured as categorical variables and Section two investigated the socio-cultural risk factors for IPV considering agreement or disagreement with statements of male superiority and the statements of acceptance of IPV. These were measured as a 4-point Likert scale from strongly agree, agree, disagree and strongly disagree.

Part A. Introduction- to be completed by the researcher team member

1	Study identification number	
2	School name	
3	Research team name	
4	Date of survey	DD/MM/YY ____/____/_____

Thank you for agreeing to be part of the study on factors influencing IPV among young women (15-24 years) in KaMPfumo municipality district. As part of the study, we would like to request you to complete this questionnaire. Please not that there are no wrong or right answers to the questions in this form.

Part B. To be completed by participants

Section 1- Demographics

	QUESTION	OPTIONS OF ANSWER	EXPLANATION
1.1	How old are you?	1. Indicate the age you complete this year 2019------	
1.2	Where do you live?	1. Area inside Kamfumo____ 2. Area outside Kampfumo____ 3. Name the area----------	
1.3	What is your completed educational level?	1. Grade 7____ 2. Grade 8____ 3. Grade 9____ 4. Grade 10____ 5. Grade 11_____	
14	Are you doing any financial activity?	1. Employed___ 2. Not working____ 3. Self employed____	
1.5	Do you consider yourself committed with any religion?	1. Yes____ 2. No____	It refers to degree to which you adhere to religious values, beliefs, and practices and uses them in daily living.
1.7	Where did you grow up? Area	1. Area Inside city____ 2. Area Outside city____	
1.8	What is your status of relationship?	1. Married___ 2. Currently in a relationship____ 3. Currently no relationship but ever had 4. Occasional partner____ 5. Never been in relationship_____	
1.9	With whom do you live (mark with x all that applies)	1. Both parents___ 2. Father only___	

		3. Mother only___ 4. Grandparent(s) 5. Extended family (aunt, uncle, etc.) ___ 6. If other, please explain_____	
1.10	With whom did you grow up (Mark with x all that applies)	1. Both parents___ 2. Father only___ 3. Mother only___ 4. Grandparent(s) 5. Extended family (aunt, uncle, etc.) ___ 6. If other, please explain_____	
Please respond about the head of your household. Consider the head of household the person who is responsible in providing subsistence for the family			
1.11	What is the highest standard or grade of the head of household?	1. Primary school___ 2. Secondary school (basic)___ 3. Secondary school (media)___ 4. Degree___ 5. Postgraduate_ 6. Alphabetic___ 7. Analphabetic___	
1.12	Is your head of household employed	1. Employed___ 2. Not working____ ____	
Partner background- please refers to your current partner or most recent partner (partner is a male partner that you have/ever had romantic relationship including sexual activities. This can be a boyfriend, spouse, or any occasional partner			
1.13	Does your current partner or most recent partner an alcohol user?	1. Yes____ 2. 2. No____ 3. Don't Know____	
1.14	What your current or most recent partner do for financial income?	1. Employed___ 2. Not working____ 4. Don't Know___	
1.15	How many years is your current or most recent partner older than you?	1. 10 years or more older____ 2. Less than 10 years older____ 3. Younger than me /same age___ 4. Don't know___	
	Section 2. sociocultural factors		
	This section constitutes the agreement with statement of male superiority		
2.1	Do you believe that a man has a superior position within a society than women?	1.Strongly agree___ 2. Agree____ 3. Disagree____ 4. Strongly disagree____	
2.2	Do you think is justified man having more than one partner if	1.Strongly agree___ 2. Agree____	

	he wants?	3. Disagree____ 4. Strongly disagree___	
2.3	More encouragement in a family should be given to sons than daughters to go to college.	1.Strongly agree___ 2. Agree____ 3. Disagree____ 4. Strongly disagree____	
2.4	In general, the father should have greater authority than the mother in making family decisions.	1.Strongly agree___ 2. Agree____ 3. Disagree____ 4. Strongly disagree____	
2.5	It is more important for boys than girls to do well in school.	1.Strongly agree___ 2. Agree____ 3. Disagree____ 4. Strongly disagree____	
2.6	Boys are better leaders than girls	1.Strongly agree___ 2. Agree____ 3. Disagree____ 4. Strongly disagree____	
2.7	Girls should be more concerned with becoming good wives and mothers rather than desiring a professional or business career.	1.Strongly agree___ 2. Agree____ 3. Disagree____ 4. Strongly disagree____	
2.8	A man can't control their sexual desire; in that way the partner must attend him when he wants sex	1.Strongly agree___ 2. Agree____ 3. Disagree____ 4. Strongly disagree____	
	Statement of acceptance of violence		
2.9	Violence between intimate partners can improve the relationship	1.Strongly agree___ 2. Agree____ 3. Disagree____ 4. Strongly disagree____	
2.10	Women sometimes deserve to be hit by their romantic partners.	1.Strongly agree___ 2. Agree____ 3. Disagree____ 4. Strongly disagree____	
2.11	A woman who makes her partner jealous on purpose deserves to be hit	1.Strongly agree___ 2. Agree____ 3. Disagree____ 4. Strongly disagree____	
2.12	There are times when violence by men to women is okay	1.Strongly agree___ 2. Agree____ 3. Disagree____ 4. Strongly disagree____	
2.13	Sometimes violence is the only way in men to express feelings	1.Strongly agree___ 2. Agree____	

		3. Disagree____ 4. Strongly disagree____	
2.14	Some women must accept violence from their partners to solve their problems	1.Strongly agree___ 2. Agree____ 3. Disagree____ 4. Strongly disagree____	
2.15	Violence between intimate partners is a personal matter and people should not interfere.	1.Strongly agree___ 2. Agree____ 3. Disagree____ 4. Strongly disagree____	
2.16	A man has all right to hit his partner, just to correct her	1.Strongly agree___ 2. Agree____ 3. Disagree____ 4. Strongly disagree____	
	Section 3- IPV experiences		
When two people have together a romantic relationship, they usually share both good and bad moments. I would now like to ask you to respond some questions about your current and past relationships and how your partner treats /treated you (since you were 15 years old). I would again like to assure you that your answers will be kept confidential and anonymous, and that to assure feasible results, I would like to ask you to try to answer all questions.			
	Physical Violence – Has he or any other partner ever did some of the following		**Has this happened in the past 12 months with your current partner or partner you had in last 12 months?**
3.1	Slapped you or thrown something at you that could hurt you?	1.____yes 2. ____no	1.____yes 2. ____no
3.2	Pushed you or shoved you or pulled your hair?	1.____yes 2. ____no	1.____yes 2. ____no
3.3	Hit you with his fit or with something else that could hurt you?	1.____yes 2. ____no	1.____yes 2. ____no
3.4	Kicked you, dragged you or beaten you up?	1.____yes 2. ____no	1.____yes 2. ____no
3.5	Choked or burnt you on purpose?	1.____yes 2. ____no	1.____yes 2. ____no
3.6	Threatened you with or used a gun, knife or another weapon against you?	1.____yes 2. ____no	1.____yes 2. ____no

	Sexual violence- Has your current or any other partner ever did some of the following acts?		**Has this happened in the past 12 months with your current partner or partner you had in last 12 months?**
3.7	Has a current or previous partner physically forced you to have sexual intercourse when you did not want to?	1.____yes 2. ____no	1.____yes 2. ____no
3.8	Did your current or previous partner ever physically force you to have sexual acts when you did not want to, for example, by twisting your arm or holding you down?	1.____yes 2. ____no	1.____yes 2. ____no
3.9	Did your current or previous partner ever force you to have sexual intercourse with him even when you did not want to?	1.____yes 2. ____no	1.____yes 2. ____no
3.10	Have you had sexual intercourse when you did not want to because you were afraid your partner might hurt or abandon you?	1.____yes 2. ____no	1.____yes 2. ____no
3.11	Did you ever have sexual intercourse when you did not want to because you were afraid of what your partner might do if you refused?	1.____yes 2. ____no	1.____yes 2. ____no
3.12	Has your partner used threats or intimidation (but not physical force) to get you to have sexual intercourse when you did not want to?	1.____yes 2. ____no	1.____yes 2. ____no
3.13	Has a current or previous partner made you do sexual things that you found degrading or humiliating?	1.____yes 2. ____no	1.____yes 2. ____no
3.14	Did your current or previous partner ever forced you to perform sexual acts (other than	1.____yes 2. ____no	1.____yes 2. ____no

	vaginal intercourse) when you did not want to?		
	Psychological Abuse- Has your current or any other partner ever did some of the following?		**Has this happened in the past 12 months with you current partner or partner you had in last 12 months?**
3.15	Called you insulting names?	1.____yes 2. ____no	1.____yes 2. ____no
3.16	Swore at you?	1.____yes 2. ____no	1.____yes 2. ____no
3.17	Yelled and screamed at you?	1.____yes 2. ____no	1.____yes 2. ____no
3.18	Treated you like an inferior?	1.____yes 2. ____no	1.____yes 2. ____no
3.19	Told your feelings were irrational or crazy?	1.____yes 2. ____no	1.____yes 2. ____no
3.20	Blamed you for his problems?	1.____yes 2. ____no	1.____yes 2. ____no
3.21	Tried to make you feel crazy?	1.____yes 2. ____no	1.____yes 2. ____no
3.22	Monitored your time and made your account for your whereabouts?	1.____yes 2. ____no	1.____yes 2. ____no
3.23	Used your money or made important financial decisions without talking to you about it?	1.____yes 2. ____no	1.____yes 2. ____no
3.24	Jealous or suspicious of your friends that restricted them?	1.____yes 2. ____no	1.____yes 2. ____no
3.25	Restricted your use of the telephone?	1.____yes 2. ____no	1.____yes 2. ____no

Would you like to make some questions?_____
_____

_____

Would you like to add some information/comments?

End of the questionnaire.

Explanation:

Religious Commitment

Is defined as the degree to which a person adheres to his or her religious values, beliefs, and practices and uses them in daily living.

Is operationalized in the contest of this study as the report in yes/no responses to religious commitment.

Intimate partner (current or previous)

Is any male partner with whom woman is having or ever had romantic relationship such as spouse/husband, boyfriend, dating partner, or ongoing sexual partner, since the age of 15 years.

Head of Household

Is the person who is responsible in providing subsistence

Appendix M

Questionário Auto Administrado (versão português)

Inquérito para investigar a prevalência e os factores associados a VPI em mulheres jovens de 15-24 anos de idade no distrito municipal KaMpfumo, na Cidade Maputo

Parte A. Introdução- a ser preenchida pelos membros da equipa de investigação

1	Número de identificação do estudo	
2	Nome da escola	
3	Nome dos investigadores	
4	Data do inquérito	DD/MM/AA ____/____/_____

Obrigada por aceitar fazer parte do estudo, sobre factores socio-culturais que influenciam a violência pelo parceiro intimo em mulheres jovens (15-24 anos de idade) no Distrito Municipal KaMpfumo na Cidade de Maputo. Como parte do estudo, gostariamos de pedir para preencher este questionário. Por favor note que não existem respostas erradas ou certas nas perguntas colocadas neste formulário.

Part B. A ser preenchida pelos participantes

Secção 1- Dados demográficoss - Nesta secção escolha apenas uma alternativa

	PERGUNTA	OPÇÕES DE RESPOSTAS	explicaçao
1.1	Em que faixa etária voce se enquadra?	1. 15-17 ____ 2. 18-20___ 3. 21-24__ 4. Marrque a idade que voce completa em 2019------	Marque neste espaço a idade em anos que completa/ou em 2019
1.**2**	Onde voce vive?	1. Area dentro da cidade 2. Area suburbana/periferia fora da cidade 3. Por favor indique o nome do bairro----------	
1.3	Qual é o teu nível de educação completo? (Indica a classe concluida em	1. 7a classe____ 2. 8a classe____ 3. 9a classe____	

	2018)	4. 10a classe____ 5. 11a classe____	
1.4	Voce realiza alguma actividade remuneravel?	1. Empregada___ 2. Nao trabalho____ 3. Auto emprego/negocio____	
1.5	Voce se considera uma pessoa comprometida com a religião? Ou cumpridora dos principios e regras da sua religião?	1. Sim____ 2. Nao____	Considere comprometida com religiao se voce se baseia nos principios religiosos para a sua vivencia no dia a dia
1.7	Em que area voce cresceu? Ou foi criada?	1. Area urbana dentro da cidade____ 2. Area rural fora da cidade____ 3. Por favor coloque o nome da região ou cidade/bairro onde voce foi criada_____	
1.8	Qual é o teu estado civil ou de relacionamento romantico?	1. Casado/vive maritalmente----_ 2. Actualmente tenho Namorado ____ 3. Actualmente sem relacionamento romantico mas já tive_____ 4. Actualmente em Relacionamento ocasional____ 5. Nunca estive em relacionamento romantico/nunca namorei_____	
1.9	Com quem voce vive? (marque com x todas alternativas aplicaveis)	1. Com pai e mae___ 2. Somente com pai___ 3. Somente com mãe___ 4. Avó (s)-------- 5. Outros familiares (tia, tio, etc.) ___	

1.10	Com quem voce cresceu ou foi criado? (marque com x todas alternativas aplicaveis)	1. Somente com pai___ 2. Somente com mãe___ 3. Com pai e mae_____ 4. Avó (s) 5. Outros familiares (tia, tio, etc.) ___	
Por favor, responda sobre o chefe de familia. Considere chefe de familia a pessoa responsavel por prover a subsistencia da familia			
1.11	Qual é o maior grau educational do chefe de familia	1. Escola primaria___ 2. Escola secundaria basico___ 3. Escola secundaria medio___ 4. Licenciatura___ 5. Mestrado/Doutorado___ 6. Alfabetizado___ 7. Nao estudou_____ 8. Nao sei-----	
1.12	O que faz o chefe de familia como actividade rentavel?	1. Empregado___ 2. Não trabalha____	
Por favor responda sobre o seu parceiro intimo. Parceiro intimo é o homem com que voce tem ou teve uma relacaco remantica que envolve relacoes sexuais, pode ser marido, namorado ou um parceiro ocasional. Considerar parceiro actual se actualmente tiver ou considerar parceiro passado se actualmente não tem parceiro mas teve desde a idade de 15 anos			
1.13	O teu parceiro intimo actual ou passado é consumidor de alchool?	1.Sim____ 2. Não____ 3.Nao sei----	
1.14	O que faz o teu parceiro intimo actual ou passado como actividade rentável?	1. Empregado___ 2. Não trabalha____ 5. Não sei____	
1.1	Quantos anos mais velho que tu é	1 Menos de 10 anos mais velho____	

5	o teu parceiro intimo actual ou passado?	2 Mais de 10 anos mais velho___ 3 Mais jovem que eu/mesma idade_____ 4 Não sei/não me lembro_____	
	Secçao 2- factores socioculturais de superioridade masculina e justificação de violencia-Diga ate que ponto voce concorda ou discorda com as seguintes afirmacoes		
2.1	Você acredita que um homem tem uma posição superior dentro de uma sociedade do que as mulheres?	1.Concordo fortemente___ 2. Concordo____ 3. Discordo____ 4. Discordo fortemente_____	
2.2	Você acha que existem razoes ou justificaçao aceitavel para o homem ter mais de uma parceira se ele quiser?	1.Concordo fortemente___ 2. Concordo____ 3. Discordo____ 4. Discordo fortemente	
2.3	Mais incentivo para ir a faculdade em uma família, deve ser dado aos filhos do que às filhas	1.Concordo fortemente___ 2. Concordo____ 3. Discordo____ 4. Discordo fortemente	
2.4	Em geral, o pai deve ter maior autoridade do que a mãe na tomada de decisões familiares.	1.Concordo fortemente___ 2. Concordo____ 3. Discordo____ 4. Discordo fortemente	
2.5	É mais importante que os meninos se saiam bem na escola do que as meninas.	1.Concordo fortemente___ 2. Concordo____ 3. Discordo____ 4. Discordo fortemente	
2.6	Os meninos são melhores líderes que as meninas	1.Concordo fortemente___ 2. Concordo____ 3. Discordo____ 4. Discordo fortemente	
2.7	As meninas devem se preocupar mais em se tornar boas esposas e	1.Concordo fortemente___ 2. Concordo____	

	mães do que em desejar uma carreira profissional ou de negócios.	3. Discordo____ 4. Discordo fortemente	
2.8	Um homem não pode controlar seu desejo sexual; dessa forma a parceira deve atendê-lo sempre que ele quiser ter relacoes sexuais	1.Concordo fortemente___ 2. Concordo____ 3. Discordo____ 4. Discordo fortemente	
	Razoes da violencia do homen contra a parceira		
2.9	A violência entre parceiros íntimos por vezes pode melhorar a relaçao entre o casal	1.Concordo fortemente___ 2. Concordo____ 3. Discordo____ 4. Discordo fortemente	
2.10	As mulheres às vezes merecem ser batidas por seus parceiros intimos	1.Concordo fortemente___ 2. Concordo____ 3. Discordo____ 4. Discordo fortemente	
2.11	Uma mulher que provoca ciumes ao seu parceiro de propósito merece ser batida	1.Concordo fortemente___ 2. Concordo____ 3. Discordo____ 4. Discordo fortemente	
2.12	Há momentos em que a violência de homens para mulheres é boa	1.Concordo fortemente___ 2. Concordo____ 3. Discordo____ 4. Discordo fortemente	
2.13	Às vezes a violência é a única maneira que os homens tem de expressar sentimentos de amor pela parceira	1.Concordo fortemente___ 2. Concordo____ 3. Discordo____ 4. Discordo fortemente	
2.14	As vezes as mulheres devem aceitar a violência de seus parceiros para resolver seus	1.Concordo fortemente___ 2. Concordo____ 3. Discordo____	

	problemas	4. Discordo fortemente	
2.15	A violência entre parceiros íntimos é uma questão pessoal e as pessoas não devem interferir	1.Concordo fortemente___ 2. Concordo____ 3. Discordo____ 4. Discordo fortemente	
2.16	Um homem tem todo o direito de bater em sua parceira, para corrigi-la	1.Concordo fortemente___ 2. Concordo____ 3. Discordo____ 4. Discordo fortemente	
	Section 3- Experiencias de VPI		
Quando duas pessoas têm um relacionamento romântico, elas geralmente compartilham bons e maus momentos. Gostaria agora de pedir-lhe para responder a algumas perguntas sobre os seus relacionamentos atuais e passados e sobre como o seu parceiro o tratou / trata (desde a sua idade de 15 anos). Gostaria de garantir que suas respostas serão mantidas confidenciais e anônimas e que, para garantir resultados viáveis, gostaria de pedir que você tentasse responder a todas as perguntas			
	Violencis física – Alguma vez na vida o seu parceiro actual ou passado fez uma das seguintes coisas?		**Isto já aconteceu nos passados 12 meses com o teu actual parceiro ou o parceiro que teve nos ultimos 12 meses?**
3.1	Deu um tapa ou jogou algo em você que poderia machucar você?	1.____Sim 2. ____Não	1.____Sim 2. ____Não
3.2	Empurrou você ou puxou seu cabelo?	1.____Sim 2. ____Não	1.____Sim 2. ____Não
3.3	Bateu você com o seu pé ou com algo mais que poderia machucar você?	1.____Sim 2. ____Não	1.____Sim 2. ____Não
	Chutou você, arrastou você ou	1.____Sim	1.____Sim

3.4	te espancou?	2. ____Não	2. ____Não
3.5	Chocou ou queimou você de propósito?	1.____Sim 2. ____Não	1.____Sim 2. ____Não
3.6	Ameaçou você com ou usou uma arma, faca ou outra arma contra você?	1.____Sim 2. ____Não	1.____Sim 2. ____Não
	Violence sexual- Alguma vez o seu parceiro actual ou passado fez uma das seguintes coisas?		**Isto já aconteceu nos passados 12 meses com o teu actual parceiro ou o parceiro que teve nos ultimos 12 meses?**
3.7	Alguma vez o seu parceiro atual ou anterior fisicamente forçou você a ter relação sexual quando você não queria?	1.____Sim 2. ____Não	1.____Sim 2. ____Não
3.8	Alguma vez o seu parceiro atual ou anterior a forçou a praticar atos sexuais quando você não queria, por exemplo, torcendo o braço ou segurando-o para baixo ou te imobilizando?	1.____Sim 2. ____Não	1.____Sim 2. ____Não
3.9	Já alguma vez o seu parceiro atual ou anterior a forçou a ter relações sexuais com ele mesmo quando você não queria?	1.____Sim 2. ____Não	1.____Sim 2. ____Não
3.1	Você já teve relações sexuais quando não queria porque estava	1.____Sim 2. ____Não	1.____Sim 2. ____Não

0	com medo de que seu parceiro a ferisse ou abandonasse?		
3.11	Você já teve relações sexuais quando não queria porque estava com medo do que seu parceiro faria se recusasse?	1.____Sim 2. ____Não	1.____Sim 2. ____Não
3.12	O seu parceiro já usou ameaças ou intimidação (mas não força física) para conseguir que você tenha relações sexuais quando voce não queria?	1.____Sim 2. ____Não	1.____Sim 2. ____Não
3.13	Alguma vez o seu parceiro actual ou anterior fez você fazer coisas sexuais que você achou humilhantes ou contra seus principios morais?	1.____Sim 2. ____Não	1.____Sim 2. ____Não
3.14	Alguma vez o seu atual ou anterior parceiro já a forçou a realizar outros atos sexuais (além do sexo vaginal) quando você não queria?	1.____Sim 2. ____Não	1.____Sim 2. ____Não
	Abuso psicológico- Alguma vez o seu parceiro actual ou passado fez uma das seguintes coisas?		**Isto já aconteceu nos passados 12 meses com o teu actual parceiro ou o parceiro que teve nos ultimos 12 meses?**
3.15	Te chamou de nomes ofensivos?	1.____Sim 2. ____Não	1.____Sim 2. ____Não
3.16	Humilhou te?	1.____Sim 2. ____Não	1.____Sim 2. ____Não

3.17	Gritou com você?	1.____Sim 2. ____Não	1.____Sim 2. ____Não
3.18	Tratou te como inferior a ele?	1.____Sim 2. ____Não	1.____Sim 2. ____Não
3.19	Disse que seus sentimentos eram irracionais ou de loucos despresando-os?	1.____Sim 2. ____Não	1.____Sim 2. ____Não
3.20	Culpou você pelos problemas dele?	1.____Sim 2. ____Não	1.____Sim 2. ____Não
3.21	Tentou fazer voce se sentir maluca ou sentir se sem valor?	1.____Sim 2. ____Não	1.____Sim 2. ____Não
3.22	Monitorou seu tempo e fez te prestar contas do seu paradeiro?	1.____Sim 2. ____Não	1.____Sim 2. ____Não
3.23	Usou seu dinheiro ou tomou importantes decisões financeiras sem falar com você sobre isso?	1.____Sim 2. ____Não	1.____Sim 2. ____Não
3.24	Ciumento ou faz suspeitas e desconfianças ou acusaçoes de voce trai-lo com os teus amigos?	1.____Sim 2. ____Não	1.____Sim 2. ____Não
3.25	Restringiu/controla/proibe o uso do seu telefone?	1.____Sim 2. ____Não	1.____Sim 2. ____Não

Fim do inquérito.

Muito obrigada pela sua participação.

Gostaria de colocar algumas questões?

Gostaria de adicionar algumas informações / comentários

_____

_____

_____

Nota: Considere parceiro actual se actualmente estiver em uma relação.

Considere **parceiro mais recente** o último parceiro com quem esteve relacionado.

Considere **últimos doze meses** os doze meses passados ate a altura do preenchimento do inquerito.

Considere **parceiro intimo** qualquer parceiro homen com quem tem ou teve relação romantica que envolve relacoes sexuais, pode ser namorado, marido, amante ou outro.

Considere se pessoa **comprometido com a religiao** se voce acredita na religião e considera o uso dos principios da sua religião nas suas atitudes e comportamentos do dia a dia.

Appendix N

List of themes, subthemes and codes

THEME	CATERGORY/SUB-THEMES	CODE
1. How did young women learned about IPV	1. Their friends shared experiences of IPV	• My friend used to tell me that her partner normally attacks her, slaps her. • When my friend is greeted by another man in the present of her boyfriend, her boyfriend did not like and slapped her. • My friend showed up with bruises and blood stains on her face she told me that her boyfriend attacked her by a cable. • My friend said to me, when she received a phone call from another man in the present of her boyfriend, the boyfriend slapped her.
	2. They witnessed their friends being physical attacked by their partners	• A friend of mine was invited by her boyfriend to his house and my friend declined he retaliated by beating her. • We were in the same house and my friend was in another room with her boyfriend, we heard her screaming and crying, her boyfriend was beating her. • we have witnessed that because she was at her boyfriend's house and when we arrived, we started to hear noise, she was screaming, and we perceived that he was beating her. When they disagreed that day, he slapped her, and all of us saw that episode.
	3. Attitude of their mothers towards IPV	• My mother told me that she would never accept abuse from my father. • When I was a little girl, my mother taught me to be independent, I don't accept to be ruled by anyone. • My mother is very independent, so I am very independent too, no man neither my father has propped my mother, even threatened or attacked her; I have been taking that with me. • I learnt from my mother that violence is not acceptable.

2. Points of view of young women on IPV	1. IPV is a violation of the rights	• when your partner obliges you to have sex • is anything that your partner does against you which you don't want. • an action done without another person's consent • is to do something that the other person wasn't prepared for and they were obliged to …could be sexual violence, he could oblige or force you to do • doing something against somebody's else will • the man doesn't accept you to use your rights
	2. What influence violence is Male Chauvinism.	• men think that women should be submitted to them • when men attach a rule, women have to follow • People take it has a normal relationship a man having many partners; he thinks is his right to have many girls. Whenever she saws the partner cheating, she should keep quiet. • after receiving lobola there is no way out of the marriage • woman is supposed to always stay at home • it wouldn't be acceptable for the woman to go back home, because she is already engaged like traditionally. because they are already married traditionally, the husband is the owner and has the right to hit her without the family's interfering • the idea that the man is superior in the home
	3. Alcohol also contributes to IPV.	• when the man is drunk, he loses control • when the boyfriend drinks he beats her • the husband was altered because of alcohol and drugs and started humiliating his wife. • Her boyfriend, he uses alcohol also used to bit her • Man uses alcohol to gain power • When man is drunk, he says "I am the man, I have power, you are women you can't do nothing against me" • because they are drunk, they are involved in fighting, unwanted sex
	4. Poor communication in couples	• lack of understanding between couples, could be violence, when they don't get along with one another • most couples do not have time to speak to each other.

		• If there's no dialogue then there's not how to get consensus, there is how violence starts. • lack of knowledge, when there is no awareness, there is not how to understand each other they think this is natural to be abused. • when there is no awareness about the relationship, there is nothing to talk about • When a woman does something wrong, the husband simply hits her without trying to understand what happened • Man uses violence as a way to communicate • I think dialogue is necessary to avoid violence
3. Reasons for acceptance of abuse by women	1. Threats from their partners	• their partners menace them saying that they can do worst. • there are men who threaten to kill their wives or their children…. • he used to treat her even on the street and she never reported him saying that she does not want a fatherless child • he said if she leaves him, he will beat her • There are women who fear their partners
	2. Because of love	• so, because of love, they do everything their husbands want. • she suffered much torture from my father for a long time with him because she loved him • She says" if I leave, someone else will come and do better" • she believes that it's just a way of showing love; she says that "the one who loves feels jealous " so she accepts that abuse, because she loves him • They say "Love is blind" … • It Is not easy for that girl to take a decision because she is deeply in love • if I don't accept his behaviour, he will break up with me
	3. Influence of Mothers as role models	• if your mother is suffering, is hit by your father and later on you meet an aggressive partner you will find it normal. • you will remember that your mother suffered with your father and they never got divorced and she never reported him. • she learnt with her mother that violence was love

		• there are mothers who suffer violence and when their daughter tells them that they are suffering the mother says it is how marriage is.
	4. Influences of friends	• friend's advice that you must stay there, don't leave the relationship • when you go outside looking for advice from the friends, they say, "keep fighting for what is yours • social networks also influence • friendships on a relationship don't help so much; girls try to solve their problem with friends • If you tell them your boyfriend is beating you, your friends will advise you to tolerate • Girls post everything about their relationship in social media • Girls also look by that side of showing off • Appearance is destroying • They say that" yesterday I made a port saying that he is my everything, today I can't post unclear messages because he beats me" • Girls only want to be in relationship no matter how
	5. Religion believes	• churches which say that virtuous woman is the one who is submissive to her husband • men think that they are our owners because of these beliefs • The woman of God always obeys and respect her husband. • God made one man for one woman and not one man for five women
	6. Financial dependence	• they have nowhere to go • they can't abandon their children • she relies on him for everything • she doesn't work she does nothing • husband is the only one who got a job • She says if she leaves him, who will take care of her children • But nowadays, girls prefer to smock and prostitution • She does nothing, she relies on him for food clothes, so she accepts these bad things
		• Growing on an environment of violence,

	7. Social acceptance of violence	• the girls who grow in such environment, they grow with that teaching that we were born to serve. a girl who grew up in such a situation is not surprised by being hit by a partner • There's always violence in the society • so, violence nowadays is, all the time, natural, • they think violence is normal because they see other couples fighting • they think that violence is natural, and she should tolerate and accept IPV
4. What can be done to help young women prevent IPV	Help women end abusive relationships Help young women seek help from family members	• teach girls that power is in both men and women. • teach the youth to give women a voice • saying that she has to careful that she has to avoid that relationship. • we should talk in other to avoid this kind of things • Talking about counselling to leave the relationship • when you are in a relationship which starts with threats and things like, you should cut it immediately • I think that everything goes wrong when we tolerate it at the first time • we girls, must learn to value ourselves • there should be more Aid stations for the victims especially the girl. • report violence with no shame • go to the nearest police station • it is better to report than living with this threat • there should be more debates, with topics on chauvinism, violence against the youth particularly the girls • they should first, seek for help seek for assistance or a family member help. • there are counseling centers for women who suffer violence they should go there to get help

Appendix O

Table 1. Characteristics of the participants

Groups	Number of participants	The age range of participants
FGD1	10	16-20
FGD2	12	15-19
FGD3	12	17-22
FGD4	10	16-19
FGD5	11	17-19
FGD6	11	17-21

Appendix P

Table 1. Socio-demographic characteristics of young women

Age categories (years) **Mean: 18 (1.514)**	**Frequency** **n=431**	**Percent (%)**
15-19	368	85.4
20-24	63	14.6
Education level (n=431)		
Grade 10	226	52.4
Grade 11	205	47.6
Religiosity (n=420)		
Committed to religion	259	61.7
Not committed to religion	161	38.4
Status of employment (n=407)		
Employed	8	2
Unemployed	399	98
Status of relationship (n=431)		
Currently married	7	1.6
Currently in relationship/dating	286	66.4
Currently not in a relationship but have had previously	138	32
Head of household status of employment (n=425)		
Employed	238	56

Unemployed	187	44
Partner alcohol use (n=431)		
Partner alcohol user	120	27.8
Partner not alcohol user	311	72.2
Partner status of employment (n=429)		
Employed	63	14.7
Unemployed	366	85.3
Partner age difference (n=424)		
Less than ten years older	188	44.3
More than ten years older	16	3.8
Younger/same age	194	45.8
Do not know	26	6.1

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