EXAMINING THE EFFECTIVENESS OF PREVENTION PROGRAMMES BEING IMPLEMENTED TO ADDRESS THE NEEDS OF WOMEN EXPERIENCING INTIMATE PARTNER VIOLENCE IN MSINGA, KWAZULU-NATAL, SOUTH AFRICA.

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DECLARATION

I, Cynthia Sanelisiwe Ndlovu, declare that

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2. This dissertation has not been submitted ever for any degree or examination at any other academia.

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Date: 28.01.2021

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ABSTRACT

As with other nations, South Africa still contends with women's subordination in society which leaves them vulnerable to many forms of violation. Existing literature claims that while policy and legislative frameworks exist to eradicate intimate partner violence (IPV) in all spheres of life, women continue to endure abuse in their private lives. Intervention programmes adopted across the globe and at the national level to address the problem have been too limited in systemically addressing IPV. Based on this foundation, this study, located in the interpretivist paradigm, investigated the effectiveness of programmes being implemented to address the needs of women experiencing IPV in Msinga, a rural area within the uMzinyathi District Municipality in the province of KwaZulu-Natal, South Africa.

The study employed a qualitative research design. The data collection methods included in-depth individual interviews and two focus group discussions. Purposive sampling was used to select 40 individual interview participants. The first set of interviews and the first focus group discussion were with the key informants (members of staff) from the organisations that were identified as dealing with cases of IPV in Msinga. The second set of interviews and second focus group discussion were held with 32 women survivors of IPV in Msinga. Both in-deth indivual interviews and focus groups discussions examined the effectiveness of the IPV programmes implemented in Msinga.

The post-structural feminist theory and the socio-ecological model were used as the theoretical framework to inform the study. Informed by this framework, findings revealed that the intersectionality of gender, race, class and ethnicity leave women from poor socio-economic upbringing more vulnerable to IPV. Henceforth, IPV unfolds in an explicit context whereby layers of disadvantage preserve women in a deprivation trap, resulting in a vicious cycle of poverty. This observation echoes that women's everyday realities are context-specific.

Against this background, the findings conclude that women's lived experiences influence how they construct the factors that perpetuate IPV in their relationships. Additionally, it was discovered that in most occurrences the emotional and physical abuse of women are interwoven and that a patriarchal system (yet again) perpatrate the oppression of women. Findings suggest that structural inequalities and the socialisation of women in Msinga contribute to individual

and societal acceptance of IPV, consequently perpetuating the subordination of women. While existing measures such as shelters for abused women provide protection, they are unable to address the structural and systemic nature of IPV. Thus, women in rural areas who experience IPV lack long-term support that is presented in a transformative and sustainable manner.

To promote effective IPV intervention, it is recommended that prevention programmes need to occur at three levels: 1) At a primary prevention level. This is critical in preventing IPV in that it intervenes with individuals, families and communities in ways that stop the perpetuation of violent behaviours. 2) At a secondary intervention level. This provides victims with information and services thereby mitigating the consequences of exposures to violence. 3) At a tertiary intervention level. This is concerned with reducing the long-term negative effects of violence. Merging primary, secondary and tertiary prevention strategies would be best particularly in communities or families that are already characterised by violence.

Keywords

Intimate Partner Violence, IPV, Women's experiences, IPV prevalence, IPV intervention programmes, Msinga.

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AIDS:	Acquired Immune Deficiency Syndrome
ANC:	African National Congress
CBO:	Community-based organisation
CARA:	Criminal Assets Recovery Account
COSH:	Church of Scotland Hospital
CEDAW:	Convention on the Elimination of All Discrimination against Women and Children
DWCPD:	Women, Children & People with Disabilities
HIV:	Human immunodeficiency virus
IMAGE:	Intervention with Microfinance for AIDS and Gender Equity
IPV:	Intimate partner violence
KZN:	KwaZulu-Natal
MDGs:	Millennium Development Goals
NGOs:	Non-government organisations
SMME:	Small Medium and Micro Enterprise
SADC:	South African Development Community
SAPS:	South African Police Services
SDGs:	Sustainable Development Goals
SLA:	Sustainable Livelihoods Approach
STIs:	Sexually transmitted infections
UN:	United Nations
UNICEF:	United Nations Children's Education Fund
WHO:	World Health Organization
VAWG:	Violence Against Women and Girls

VEP: Victim Empowerment Programme

CHAPTER 1

INTRODUCTION AND STUDY BACKGROUND

1.1 CONTEXTUALISING INTIMATE PARTNER VIOLENCE

Women are often subjected to violence by men in either intimate relationships or other interactions. According to Ackerson and Subramanian (2008), one in three women globally has experienced psychological, physical or sexual partner violence in their lifetime. Ackerson and Subramanian (2008) further state that while intimate partner violence (IPV) is a universal problem, it is a problem of extreme magnitude in less developed countries and is more prevalent in societies where there is a culture of violence and where male superiority is treated as the norm. Joyner (2015) et al confirm that cultural and social norms are highly influential in shaping behaviour in an intimate relationship. Lau (2009) explains IPV as violence that takes place between individuals in an intimate relationship. Other researchers use gender-based violence (GBV), IPV and domestic violence interchangeably. "GBV is the general term used to capture violence that occurs as a result of the normative role expectations associated with each gender, along with the unequal power relationships between the two genders, within the context of a specific society" (Bloom 2008:14). However, it has been widely acknowledged that the majority of persons affected by GBV are women and this is a result of the unequal distribution of power in society between women and men. IPV is, therefore, one of the forms of GBV which happens in intimate relationships. Research done by the World Health Organization (WHO) (2013) on the prevalence and health effects of IPV shows that 35% of women have experienced either sexual or physical IPV globally.

Statistics on femicide, rape and IPV reveal unprecedented prevalence rates. South Africa's 2016 Demographic and Health Survey indicates that one in five women older than 18 has experienced physical violence. This figure is allegedly higher in the poorest households where at least one in three women has reported physical violence. Shockingly, the Medical Research Council in 2009 reported that three women die at the hands of their intimate partner every day. This femicide rate is five times more than the worldwide average. It is also reported that South Africa's rate of sexual violence is one of the highest globally. This is despite the country being characterised by a strong legislative and policy-enabling environment that is aligned with

international conventions that seek to protect and promote the rights of women. At the same time, a comprehensive set of government programmes and dynamic civil society organisations (CSOs) are providing indispensable services to women. Thus, notwithstanding the myriad of legal protections and interventions by state and non-state actors, women in South Africa continue to experience extremely high rates of violence. This raises human security concerns for women predominantly and for the country at large. It also begs the question of why IPV persists in South Africa, particularly in KwaZulu-Natal (KZN). It is important to understand the drivers of IPV in Msinga to learn what needs to be done to address these issues. Msinga is a rural community situated in KZN and has been cited as the worst-performing municipality in the country in terms of access to basic services (Motlafi 2017).

The *ukuthwala* culture persists in KZN and has been identified as one of the drivers of HIV infection in the province (Karimakwenda 2011). Karimakwenda (2013) further states that many of the coercive aspects of ukuthwala have been condemned as newly deviant and antithetical to the way marriage traditions were practiced in the past and he argues that these illustrations of ukuthwala and traditional marriage are inaccurate. Semantically the word "*ukuthwala*" has a variety of different meanings in isiZulu. However, in this instance, I will only define the culture of *ukuthwala* that is associated with abuse when it is not done correctly. According to Nkosi and Wassermann (1994), *ukuthwala* can refer to the act of compelling the opening up of the marriage negotiation process when it is proving difficult to do so under normal circumstances. Crudely, this is done by the actual carrying away of a young woman by a group of young men to the house of the young man who aims to marry her. In most cases, during the process of *ukuthwala*, the prospective husband is also present with a group of his peers to identify the woman he loves and whom he aims to carry away with marriage as the intention (Nkosi and Wassermann 1994). This also forces the woman's family to endorse marriage negotiations. *Ukuthwala* in this form is one common type of GBV in the province that is carried out under the guise of culture. Men's control over women is seen as a mark of masculinity. Culture, religion and media reinforce these norms and promote the view that men should be in power within homes and public institutions while women should be in a position of subservience. LifeLine Pietermaritzburg and Motlafi (2017) also confirm that the Msinga community has a history of communal violence and has practices such as *ukuthwala*, in which a young girl is kidnapped by an older man for marriage, all of which have dire implications for IPV in the community.

Given the above, the Msinga area is a significant one in terms of examining and understanding the involvement of organisations in IPV and their prevention and intervention strategies in this regard. There are four NGOs (the Khayelisha Care Project; the uMusa woMsinga Project; LifeLine and Rape Crisis; and the Sinozwelo Resource Centre) who confirmed that they are combating and responding to issues of IPV in Msinga. It is noted that while these NGOs had programmes that were preventing and responding to IPV, they were working in silos which makes it difficult for their efforts to be acknowledged and recorded. This research contributes to documenting the organisations' responses to IPV in Msinga and supplements the body of knowledge on IPV prevention strategies. It does so from the experiences and insights of survivors of IPV from the Msinga area.

Women's quality of life the world over and predominantly in South Africa has long been perceived as restricted by the balance of social power which is tilted in favour of the male species. The literature reviewed for this study confirms that IPV is a substantial element of women's experiences in South Africa (WHO 2012; Turshen 2000; Kilburn & Pettifor 2019). In addition, socio-economic uncertainties, repeatedly worsened by women's limited access to education, capital, labour opportunities and resource control, further compound this situation (Coates et al 2007; Fong et al 2016). The persistence of IPV is both a process and conflict that oppresses women while concurrently expressing the pathologies of society. The evidence reveals that most survivors of IPV experience violence throughout their lives. For example, all of the participants in this study had experienced abuse more than once and across different periods in their lives. Moreover, IPV is interwoven with relations of power and feeds on, and persuades, multiple vulnerabilities including disability, economic dependence, identity-based inequalities and the personal circumstances of women and children.

IPV is a problem affecting millions of people globally and this problem manifests in various forms, for instance, in the context of marriage or cohabitation (Lynn 2004). Increasing evidence of the effect of IPV on women is noted from studies conducted in several countries such as the USA, Kenya, India, Rwanda, Tanzania and South Africa. The prevalence of alleged IPV in South Africa is relatively high but the prevalence of reported IPV is low. The study by Groves et al (2015) on the prevalence and rates of IPV among South African women during pregnancy and the postpartum period, revealed that more than 20% of all women experienced at least one act of physical, psychological or sexual IPV during pregnancy.

It has been over two decades since South Africa transitioned to democracy and the nation is perceived in the eyes of the international community as a regional example of democratic and social rebirth. As noted, the country is characterised by a robust legislative and policy-enabling environment that is affiliated with international conventions that pursue to safeguard and promote the rights of all women. At the same time, a wide-ranging set of government programmes and dynamic CSOs are offering indispensable services to women. Yet, notwithstanding the myriad of legal protections and programmes by state and non-state actors, women in South Africa continue to experience extremely high rates of violence. The study Women, Children & People with Disabilities (DWCPD) commissioned by Health and Development Africa (HDA) (2013); Brobbey et al (2017); and Shail et al (2015) confirmed that South Africa does indeed have a strong legislative and policy framework aligned with international conventions that seek to protect and empower women, as well as a comprehensive set of government programmes and dynamic CSOs. Furthermore, researchers such as Heis and Garcia-Moreno 2002; Campbell 2002; Koening et al 2003; Zablotska et al 2009; and others have examined the nature of the violence and the contributing factors. These studies have laid out interesting findings which could inform IPV prevention programmes. However, there is still no clear literature on the role played by organisations that deal with IPV issues and the effectiveness of their programmes in the Msinga area.

Numerous studies, including evaluative and exploratory assessments of IPV, have yielded explanations that identify structural problems, the violent legacy of the apartheid state and contemporary social glitches as accounting for IPV in South Africa. One needs to bear in mind that these explanations have for decades been put forward to understand IPV and to improve approaches to transformation without success and the situation thus presents an impasse. Additionally, the lack of success throws a cloud over the efforts to combat IPV in South Africa. In the face of insistent IPV in the country, an altered approach to understanding it should inform our perceptions of the issue and how to tackle it. Over and above the "known" and specified explanations for IPV, there is perhaps a need to further examine the effectiveness of the programmes being implemented to address the needs of women experiencing IPV through the lenses of those who experience it. This appears to be a gap in the existing studies which aimed at recommending new or improved approaches concerning the phenomenon of IPV.

Chambers (2014) stated that the poor are those who are powerless to make decisions due to physical weakness, isolation and limited access to finances, skills and knowledge. During the

apartheid period in South Africa, government policies ensured that poverty affected more Black people than other racial groups. Coovadia, Jewkes, Barron, Sanders and McIntyre (2009) argued that Black South Africans worked as labourers earning "peanuts" to provide for their households while generating wealth for the White minority. South African society continues to contend with the legacy of apartheid. Times Live (2017) confirmed that in 2017, 46% of Black African women were jobless, compared to 39% of the Coloured population, with Indians/Asians at 34% and Whites at 22%. In a similar vein, Stats SA (2011: 52) found that Black African women were disproportionately affected in terms of unemployment rates, that is, 41.2% compared with White women at 6.9%. According Stats SA (2021) the number of unemployed persons remained almost unchanged at 7,2 million compared to the fourth quarter of 2020 (increased by 8 000). It has been claimed that the unemployment rate is higher among rural women when compared to that of women living in urban areas (Aliber 2003). Msinga is one of the rural areas whose women are stricken by poverty and high rates of IPV.

The Msinga Local Municipality, within which this study was conducted, is rural in nature with the majority of its land held by the Ingonyama Trust. It is graded low in measured socio-economic indicators and, as mentioned, is the worst-performing municipality in terms of the provision of basic services to households. Msinga is among 57 of the poorest wards in KZN and has been identified for intervention in the long term (Lottering et al 2020). It is noted that IPV is prevalent in under-resourced communities since families in such backgrounds are hard-hit by poverty, unemployment, powerlessness and physical weakness. Chambers (2014) stated that these elements interact to keep deprived people in a deprivation trap. Furthermore, South Africa has one of the highest rates of violence in the world when compared with other countries (Kamineer, Grimsrud, Meyer, Stein & Williams 2008). Pretorius and Bester (2009) revealed that one in four women in dating relationships has experienced violence at some time in their lives. IPV is the one the main sources of death in South Africa with 8.8 deaths per 1 000 women (Pretorius & Bester 2009) together with acquired immune deficiency syndrome (AIDS), cancer, traffic accidents, malaria and muggings combined (Devries, Watts, Yoshihama, Kiss, Schraiber, Deyessa, Durand, Mbwambo, Jansen & Berhane 2011). It was discovered that in South Africa a woman dies every eight hours, on average, at the hands of an intimate partner (Medical Research Council 2017). Furthermore, the abuse not only negatively impacts on women but the entire family and the community (Ruiz-Hernandez, García-Jiménez, Llor-Esteban & Godoy-Fernández 2015).

The environmental, social, economic, political and cultural background of the Msinga local municipality is complicated. As a result, it is not an accommodating area for using "dialogue" as an intervention for IPV. Manifold deprivations of basic services, homesteads sprawled across mountainous terrain, weak road infrastructure, low levels of formal education, the omnipresence of violence and the characteristics of Zulu culture contradict with the constitutional values of individual rights and a very strong implementation of intervention programmes to win the fight against IPV is required.

Even though there are NGOs such as LifeLine and Rape Crisis, the Khayelisha Place of Safety, the Snozwelo Resource Centre and uMusa woMsinga under the Noyibazi Clinic in Msinga that are dealing with issues of GBV, IPV cases are still escalating and this continues to alarm. The NGOs, through counselling and support groups, offer life orientation such as life skills, guidance and psychosocial support. According to the programme managers, they attend to approximately 80 new cases of GBV, particularly IPV, against women per month.

Grounded in post-structural feminism and socio-ecological theories this study, therefore, examined the effectiveness of programmes being implemented to address the needs of women survivors of IPV in Msinga, KZN, South Africa. The research investigated IPV programmes and their underlying assumptions in the literature and dominant discourses, through the explanations, standpoints and experiences of women survivors and programme implementers. It focused on women as the "knowers" of and expert authorities on their own experiences which frequently take place on the limits of society and signify their subjective knowledge.

There is a striking lack of research on the effectiveness of IPV programmes in Msinga. The purpose of this study was to broadly examine the effectiveness of programmes being implemented to improve the survival of women experiencing IPV in the area. It was anticipated that the study will make a significant contribution to documenting the organisations' responses to IPV in Msinga, add to the body of knowledge on using prevention strategies to respond to IPV, and strengthen the intervention programmes.

1.2 RESEARCH PROBLEM

IPV is a human rights violation, a gender issue and a public health concern. There are various strategies and programmes designed and implemented by different organisations to diminish

such violence. Substantial effort is focused on the protection of victims, legal actions against the perpetrators as well as empowerment of the victims. However, the role of the organisations dealing with abused women as a result of IPV in Msinga is not known and whether the prevention strategies they employ are effective. Therefore, this study examined the prevention strategies at three levels, namely, primary, secondary and tertiary. Primary prevention is critical to preventing IPV in that it intervenes with individuals, families and communities in ways that stop the perpetration of violent behaviours. On the other hand, secondary prevention provides victims with information and services thereby mitigating the consequences of exposure to violence. Tertiary prevention is concerned with reducing the long-term negative effects of violence. Merging primary, secondary and tertiary prevention strategies is ideal, particularly in communities or families that are already characterised by violence. This study evaluated the effectiveness of the programmes designed for IPV and interrogated whether they employed prevention strategies at the three levels.

1.3 RESEARCH OBJECTIVES AND KEY QUESTIONS TO BE ASKED

1.3.1 Objectives

1. To investigate the experiences of women survivors of IPV in Msinga.
2. To identify the prevention strategies employed by organisations dealing with IPV in Msinga.
3. To examine the effectiveness of the prevention programmes addressing the plight of IPV survivors.
4. To propose policy recommendations for handling IPV cases.

1.3.2 Central research question

What are the experiences of women survivors of IPV and effectiveness of programmes being employed by organisations dealing with IPV in Msinga, KZN, South Africa?

1.3.3 Key research questions

1. What are the experiences of women survivors of IPV in Msinga?
2. What are the prevention strategies employed by organisations dealing with IPV in Msinga?

3. What is the effectiveness of the prevention programmes addressing the plight of IPV survivors?
4. What gender policy recommendations are needed to improve the handling of IPV cases?

1.4 RESEARCH DESIGN AND METHODOLOGY

The study is a qualitative one located in the interpretivist paradigm. The interpretivist paradigm is concerned with understanding the world as it is from the subjective experiences of individuals. Aikenhead (1997) argued that the interpretivist paradigm is underpinned by observation and interpretation; consequently, to observe is to collect information about events, while to interpret is to make meaning of that information by drawing inferences or by judging the match between the information and some abstract pattern. The paradigm stresses the need to put analyses in context (Reeves & Hedberg 2003:32). Characteristics of the interpretivist perspective that are relevant in the context of the study are:

- Purpose of the research,
- Ontology - the nature of reality,
- Epistemology - the nature of knowledge and relationship between the inquirer and the inquired-into, and
- Methodology used (Cantrell 2001).

Denzin and Lincoln (2008) claim that qualitative studies are naturalistic, descriptive and interpretive as they are primarily concerned with developing explanations of a social phenomenon. They shed light on the social world in which people live and, likewise, explain why things are the way that they are (Ritchie, Lewis, Nicholls & Ormston 2013). Henning et al (2004) believe that these studies value people's lived experiences and the social and economic relations that structure these experiences. The data for this study was collected from a purposively selected sample of 32 women who experienced IPV and eight staff members from four NGOs that were employing IPV intervention programmes in Msinga. In-depth semi-structured interviews were used to gather data. Applying the steps suggested by Attride-Strilling (2001), thematic analysis directed the analyses of the data by coding and summarising the thematic network and interpreting patterns.

1.4.1 SIGNIFICANCE OF THE STUDY

Research on the scourge of IPV in South Africa has mainly focused on providing forms of IPV, consequences of IPV and some strategies. Research in rural areas, particularly on the experiences of women survivors of IPV and the effectiveness of the intervention programmes being employed in response to IPV, is minimal and only recently emerging. The voices of rural women in the context of IPV will be heard. This study aimed to contribute to the literature through understanding issues around IPV, including intervention programmes, from the perspectives of IPV survivors, victims and intervention programme implementers, especially within the rural context.

Findings from the literature endorse the necessity of attempting to understand the experiences of women survivors of IPV and the effectiveness of programmes being employed by organisations dealing with IPV. Therefore, this research highlights the significance of examining the effectiveness of the intervention programmes aimed at responding to IPV issues. The findings of the study could be valuable to journals dealing with violence and abuse, particularly within the South African context; to GBV policy designers; to anti-gender violence activists; and to women and survivors themselves in propelling them to be aware and knowledgeable about IPV and consequently make well-informed decisions. It is imperative to contribute to the knowledge base on community-based and locally developed programmes to address IPV by examining the effectiveness of the interventions in Msinga.

1.5 OVERVIEW OF CHAPTERS

The dissertation consists of eight chapters:

Chapter 1: Introduction and study background. This chapter contextualised IPV. In doing so, it provided the background to the study, the problem statement, and the objectives and key questions of the study. This was followed by an overview of the value of the study as well as a brief description of the design and methodology employed.

Chapter 2: Literature review and theoretical framework. This chapter reviews the literature in the form of published research and unpublished reports and documents. It also provides an

overview of the theoretical frameworks that underpinned the study. In this regard, post-structural feminism and socio-ecological theories are discussed in detail.

Chapter 3: Research methodology and methods. This chapter presents the qualitative research design that was applied to collect the data. The research design and the sampling, data collection and data analysis methods are discussed. A description of the ethical aspects and fieldwork challenges of the study end the chapter.

Chapter 4: Experiences of intimate partner violence among women in Msinga. This chapter discusses the lived experiences and life circumstances of women survivors of IPV in Msinga, KZN.

Chapter 5: Effectiveness of primary intimate partner violence strategies employed in Msinga. This chapter focuses on the primary prevention strategies implemented by the four NGOs in Msinga in attempting to prevent the occurrence of IPV.

Chapter 6: Effectiveness of secondary intimate partner violence strategies employed in Msinga. In this chapter, the secondary IPV intervention programmes offered by the four NGOs are described and discussed.

Chapter 7: Effectiveness of tertiary intimate partner violence strategies employed in Msinga. This chapter is the final one relating to the findings of the study and examines the tertiary IPV programmes implemented.

Chapter 8: Recommendations and implications of the study. This chapter talks to the gender policy recommendations needed to improve the handling of IPV cases as well as the implications of the study. It summarises the study's main findings and offers recommendations as well as suggestions for future research.

CHAPTER 2

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 INTRODUCTION

In the previous chapter, I discussed the direction of the study. This chapter encompasses background information on IPV. It reviews the existing literature on IPV and establishes the gaps in the literature. Drawing from different contexts and with specific consideration of the South African situation, this chapter deliberates the various angles from which to understand IPV. This review will include the definition of IPV, its wide-ranging prevalence, the causes and impacts of IPV, IPV against men and the intervention programmes implemented to address it. By so doing, the need for this study will be further validated. Furthermore, the two theories which have inspired this study from conception to finish, namely, post-structural feminism and the socio-ecological model, will be discussed. These theories will not only be used to understand the risk factors that affect women in the communities in which they live but also to consider what intervention programmes they should undertake to address and reduce these factors.

2.2 DEFINITION AND TYPES OF INTIMATE PARTNER VIOLENCE

2.2.1 Definition of intimate partner violence

According to Seedat et al (2009), IPV commonly occurs within relationships when one partner, particularly a man, begins a controlling behaviour and causes a sense of fear in women. Patriarchal social norms sanction the practice of violence by men to reprimand and control female partners, and as long as boundaries of severity are not transgressed, the violence is viewed as socially acceptable. Gilfus, Trabold, O'Brien and Fleck-Henderson (2010) defined IPV as a constellation of abusive and controlling behaviours. The WHO (2014) described IPV as behaviour by an intimate partner or ex-partner that causes physical, sexual, or psychological harm, including physical aggression, sexual coercion, psychological abuse, and controlling behaviours.

Numerous studies have shown that women experience IPV more frequently than men. For example, Fincham et al (2009) claimed that 5.3 million cases of IPV occur against women while 3.2 million cases are against men. Women are more vulnerable to the harmful effects of IPV and are said to be seven to 14 times more likely than men to suffer severe physical injury from violence by an intimate partner (Ghandi et al 2010: 343). The study conducted by Gearon et al (2003) on gender differences in IPV, found that 55% of women interviewed had experienced both physical and sexual abuse. Silverman et al (2001), in line with the point made above, argued that most IPV acts are directed at women. The authors also stated that the rate of violence against women by intimate partners was three to six times that of violent acts against males. Injuries that result from such violence are far more common among women for both adolescent and adult groups, and approximately 10% of intentional injuries to adolescent girls are reported to be the result of partner violence. According to Ghandi et al. (2010), IPV incidences are estimated at 7.7 million per annum and that the occurrence of IPV is 25.5% among women and 8% among men in the general population. Coker et al (2000) argued that even though males and females seemed to both report experiences of violence in dating relationships, females were more likely to report severe violence and injuries. Matud (2007) discovered that in 48 population-based studies from around the world, between 10% and 69% of women reported physical abuse by an intimate partner and that for many of these women physical abuse was part of a constant pattern of abuse. In the USA, IPV is of concern to women irrespective of their age. Nevertheless, adolescents and young women are the most vulnerable compared to any other group in that country as well as the rest of the world (Family Violence Prevention Fund 2010). According to Fincham (2008), IPV is not only limited to more established intimate relationships such as marriage and cohabitation but is also predominant in dating relationships.

2.2.2 Types of intimate partner violence

Different types of IPV amongst adults and youth have been observed in South Africa and it increases with age. For instance, the first national youth risk behaviour survey of more than 280 000 secondary school learners in South Africa discovered that 9.8% of adolescent girls and boys aged 15 years reported having being forced to have sex in the past year (Flisher et al 2007). It was further found that the incidence of IPV rose to 13% for males and 16% for females by the age of 19 years (Flisher et al 2007). The learners also declared that the violent nature of sexual initiation ranged from emotional intimidation and threats to physical beatings. For

example, 22 out of 24 interviewees (92%) reported having been beaten up by their partners (Flisher et al 2007). Feder, et al (2021) argue that violence against women remains devastatingly pervasive and starts alarmingly young, shows new data from WHO and partners. Across their lifetime, 1 in 3 women, around 736 million, are subjected to physical or sexual violence by an intimate partner or sexual violence from a non-partner and this number has remained largely unchanged over the past decade (Feder, et al 2021). Statistics show that at least one in four women in South Africa has experienced violence and 40% of men have been culprits of this form of violence. It is widely acknowledged that while only a small percentage of rape cases are reported to police in South Africa, the country still has one of the highest numbers of reported cases of rape in the world (Meel 2008). Notwithstanding the increased attention been given to dating violence among adolescents, knowledge is still somewhat limited, particularly regarding partner violence among women from remote areas in South Africa and KZN in particular.

Researchers like Johnson (2008), Stark (2007) and Dutton (2005) indicate that physical, sexual, psychological and economic abuse, as well as stalking, are the five multi-faceted methods of violence and abuse that perpetrators utilise to achieve, maintain and regain control of their intimate partners. However, the authors also acknowledge that forms of abuse are not limited to the aforementioned. Coercion or terroristic intimidation, coupled with any of the five methods of abuse, comprise IPV. Straus (1979) confirmed that much IPV research has focused solely on physical violence and psychological abuse, overlooking sexual abuse by intimate partners. Similarly, and more recently, Dutton (2005), Klein (2009), Stark and Buzazwa (2009) and Stark (2007) argued that much of the research on IPV has focused specifically on violent behaviours that are crimes under state statutes, particularly assault and homicide. Finklehor and Yllo (1985) pointed to economic abuse and stalking which are both part of the definition of IPV adopted.

2.2.2.1 Physical intimate partner violence

The NSO et al (2012) survey scrutinised specific forms of physical violence. The most common forms of physical violence experienced among both females and males were beating, hitting and battering. However, the experience of these forms of abuse was twice as high among females as compared to males (24.5% versus 12.4%). The MDHS (2010) survey collected evidence on described physical injuries resulting from IPV. It found that amongst those who

had experienced sexual or physical IPV, 32% had cuts, bruises or aches; 10% had eye injuries, sprains, dislocations or burns; 9.8% had deep wounds, broken bones, broken teeth or another serious injury; while 35% experienced one or more of these injuries. The earlier MDHS (2004) survey found that of those who had experienced sexual or physical IPV, 22.9% had bruises and aches; 5.0% had injuries or broken bones and 6.4% sought a doctor or health centre's medical services. The MDHS (2004) survey also found that women who had experienced sexual violence including forced sex by either an intimate partner or non-partner in the last 12 months, were approximately 70% more likely to report incontinence than women who had not experienced this violence (Peterman & Johnson 2009). Ellesberg and Heise (2005) indicated that the deliberate use of physical force with the potential for causing death, injury or harm comprises, but is not limited to, scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, poking, hair pulling, slapping, punching, hitting, burning and the use, or threat to use, a weapon (gun, knife or object).

2.2.2.2 Sexual intimate partner violence

For some women and girls, sexual coercion and abuse are defining features of their lives. Enforced sexual contact can take place at any time in a person's life, especially a woman's life, and includes a range of behaviours from forcible rape to non-physical forms of pressure that compel women to engage in sex against their will. Studies conducted by Heise (1995) and the WHO (1997) revealed that the majority of non-consensual sex takes place among individuals who know each other, such as spouses, family members, dating partners or acquaintances. Hakimi et al (2002), Jewkes et al (2002) and Jewkes and Abrahams (2002) argued that much non-consensual sex takes place within consensual unions and includes a woman being compelled to have sex when she does not want it, or to engage in types of sexual activity that she finds degrading or humiliating.

Sexual behaviour that is illegal such as rape, attempted rape, involuntary deviant sexual acts, sex trafficking and others is a limited set of the full range of sexual violence perpetrated by intimate partners (Hamby & Koss 2003). The spectrum of abusive sexual acts includes the following: unwanted, non-consensual or coerced sex; compulsory or denial of contraception and abortion; sex after childbirth or during illness; unwanted intercourse during menstruation; sex during sleep; sexual humiliation and degradation; sexually proprietary behaviours, for example, jealousy, nagging about sex and accusations of infidelity; "makeup" sex following

physical assault or perceived infidelity; virginity and vaginal inspections; commercial sexual exploitation of partners; infibulation and other mutilation; sex through trickery, fraud or misrepresentation; sexual abuse by proxy or viewing/acting out pornography; exposure of children to sexual acts; economic support conditional on sex; and, finally, non-consensual sex with third parties, animals or objects.

Intimate partner sexual violence frequently incorporates hurtful dimensions of deprivation and humiliation (Logan 2007). There is limited research on sexual violence by batterers or its impact on victims. Most of the research on intimate partner sexual violence has mainly focused on forced or involuntary sex that is actionable under state criminal statutes. Even the National Crime Victimization Survey (NCVS) and the National Violence Against Women Survey (NVAWS) asked few questions to elicit evidence beyond coercive sexual behaviour and reflected significantly low rates of intimate partner sexual violence (Tjaden & Thoennes 2007). Finklehor and Yllo (1985) and Russell (1990) pointed out that early research on sexual violence against wives, not just battered wives, indicated that between 10% and 14% of married women were raped by their husbands. According to the NVAWS, 17% of women are raped at some point in their lives and this percentage includes intimate as well as acquaintance and stranger rape. Women comprise 86% of rape victims but only 20% of women victims report their rape incidents to the police (Tjadena & Thoennes 2007). It has been noted that male sexual violence on intimate female partners is more predominant than stranger and acquaintance sexual violence with between 14% and 25% of women experiencing intimate partner sexual violence (McFarlane & Malecha 2002).

Trafficking in women and girls for forced labour and sexual exploitation is another type of GBV that has speedily grown during the past decade largely as a result of war, displacement, and economic and social inequalities between and within countries (Ellsberg & Heise 2005). Even though reliable statistics on the number of women and children who are trafficked are lacking, rough estimates suggest that from 700 000 to two million women and girls are trafficked across international borders every year (Michau 2002; Zimmerman et al 2003 and Orhant et al 2002). These women are exposed to many risks including physical violence and rape in their work and when trying to negotiate safer-sex practices. A further aspect of GBV that has been mostly discounted until recently is violence against women in situations of armed conflict. Topical reports have documented systematic rape in many conflicts involving the former Yugoslavia, Rwanda, Liberia, Sierra Leone and Uganda (Swiss et al 1998; Ward &

Vann 2002). These reports have emphasised the extent to which rape has been used as a deliberate strategy. Ward and Vann (2002) further mentioned that it destabilises the population, advances ethnic cleansing, expresses hatred for the enemy and supplies combatants with sexual services. In 2002, the International Criminal Tribunal in The Hague acknowledged the significance of sexual offences in war and labelled them as a crime against humanity. International relief agencies are also calling for assistance with the precarious condition of women in refugee settings where rape, child sexual abuse, IPV and other forms of sexual exploitation are widespread.

2.2.2.3 Stalking in an intimate partner relationship

Stalking may be discounted because it may not contain immediate physical violence against victims. According to the NVAWS (cited by Tolman 2011), 22.1% of females and 7.4% of males who were stalked were physically assaulted by their stalkers. The Supplemental Victimization Survey (SVS) cited by Bannerman (2010) discovered that 21% of all stalking victims reported attacks on themselves and 15% reported attacks on third parties or pets. According to Breiding et al (2015), the National Intimate Partner and Sexual Violence Survey conducted in the USA in 2011 revealed an estimated 15.2% of women (18.3 million women) had experienced stalking during their lifetime which made them feel extremely terrified and sometimes paranoid. Stalking behaviours convey implicit intimidation and the threat of violence and harm to victims. A little more than a quarter of victims were contacted between once a day and once every two to three days, 36% weekly and 21% monthly (Tolman 2012).

The SVS found that in addition to receiving unwanted phone calls (62.5%) and letters or emails (30.1%), stalking victims experienced high levels of four unwanted behaviours which are commonly associated with stalking: spreading gossip about the victim (29.1%), following or spying on the victim (24.5%), showing up in places without an appropriate reason (22.4%) and waiting outside (or inside) places for the victim (20.4%). Almost half of the victims (46%) experienced at least one unwanted contact per week. The SVS, conducted in 2006, also discovered that a little over a quarter of stalkers specifically engaged in cyberstalking or electronic monitoring of their victims and a little under a quarter (24.4%) vandalised the victim's property or that of someone in the victim's household (Baum 2009). According to Pittaro (2007), a study conducted in 2001 on cyberstalking suggests, however, that despite the growing threat of cyberstalking, law enforcement has mainly failed to identify it in practice.

Across the entire state of Rhode Island, police recognised only one cyberstalking occurrence between 2001 and 2005 although the state had endorsed a specific cyberstalking law in 2001 (Klein et al 2007).

The NISVS found that 16.2% of women were stalked over their lifetime and 4.3% over the year before the survey. Two-thirds of the women were stalked by current or former intimate partners. In terms of tactics used by stalkers, more than three-quarters of women reported receiving unwanted phone calls, voice or text messages or hang-ups. More than half were approached and more than a third were inspected, followed or tracked (Black et al 2011). Like violence in general, not all stalking victims report their being stalked to the authorities. Stalking reporting rates were shown as 41% in the SVS and 51.9% in the NVAWS. Kellogg (2009) and Tjaden and Thoennes (2001) stated that through complex occurrence surveys, researchers have determined that most stalking victims do not use the term "stalking" to describe their victimisation. Notwithstanding the low victim reporting rates, according to the SVS, almost all reports of stalking are made by the victims and not third parties.

2.2.2.4 Specific forms of psychological intimate partner violence

Levels of IPV psychological abuse have been studied less as compared to other forms of IPV abuse. Psychological abuse includes controlling and coercive behaviours that diminish liberty and result in micro-management of everyday life. Controlling behaviour describes a variety of acts designed to make a person feel inferior and/or dependent. Victims of psychological violence are isolated from sources of support; their resources and capacities for personal gain are exploited; their means for autonomy, resistance and escape are deprived; and their everyday behaviour is regulated without their consent. The National Institute for Health and Care Excellence (NICE 2013) described coercive behaviour as an act or pattern of acts of assault, threats, humiliation, intimidation or other abuse that is/are used to harm, reprimand, or frighten their victim. In a study conducted in Europe, it was found that 43% of women across the continent have experienced some form of psychological abuse by an intimate partner (current or previous) since the age of 15. This comprised psychologically abusive behaviour and other types of psychological violence, including controlling behaviour, economic abuse and blackmail. In terms of countries, levels range from 60% of women in Denmark and Latvia to 30% in Ireland, Greece and Spain. As from as early as the age of 15, almost half (46%) of the

women in the UK sample reported experiencing some form of psychological abuse from relationship partners.

Any conduct or omission that damages the self-esteem, identity or development of the individual falls within psychological abuse. It includes, but is not limited to, humiliation, threatening the loss of custody of children, forced isolation from family or friends, threatening to harm the individual or someone they care about, recurring shouting or degradation, inducing fear through threatening words or gestures, controlling behaviour, and the destruction of possessions (Ellesberg & Heise 2005).

2.2.2.5 Economic intimate partner violence

Preventing a woman from shopping autonomously or from working outside the home are considered forms of economic violence, a subsection of psychological violence. Barbara et al (2013) stated that in total, 5% of women have experienced this form of abuse within their current relationship and 13% within a previous relationship. Economic violence by an intimate partner comprises controlling a victim's ability to acquire, use, manage, maintain and dispose of economic resources. Almost all offenders of IPV impose various tactics of economic abuse on their partners. Tactics of economic violence include, but are not limited to, prevention or disturbance of education and/or employment, interference with transportation, failure to afford childcare, compromising housing, deprivation of food and medicine, disruption of sleep, destroying work clothes and/or job-related manuals, disposal of assets, theft of income, denial of library or internet access, commercial sexual exploitation, and limitation of communication with economic support networks (Barbara et al 2013). Researchers like Adams et al (2008), Tolman (2011) and Tolman and Rosen (2001) stated that several women victims of IPV suffer substantial material deprivation as a consequence of economic violence. Most low-income victims pursuing domestic violence relief stated that the material hardships they faced were triggered by abusive partners.

2.3 CAUSES AND IMPACT OF INTIMATE PARTNER VIOLENCE

2.3.1 Causes of intimate partner violence

Any attempt to avoid IPV is grounded on an implicit theory of what causes specific men to violate their partners. Therefore, research and theory on what escalates the possibility of IPV are extremely pertinent to the planning, implementation and assessment of programmes intended to minimise issues of IPV. Heise (2011) indicated that in the 1970s and 1980s, knowledge on IPV developed mainly from theory and research originating from secluded academic disciplines, namely, sociology, criminology, psychology and feminist theory. Each of these analysised the occurrence of IPV with the isolated lens of its discipline. The following were found as the real or root causes of IPV: the history of communal violence, traditional values versus legislation, economic challenges and social learning modelled on parents' behaviour and patriarchy. Unsurprisingly, heated deliberations followed over whether certain aspects like substantial usage of alcohol, poverty and patriarchal gender customs were in some way connected to IPV against women (Heise 2011).

2.3.2 Impact of intimate partner violence on women

The effect of IPV is multi-layered and wide-ranging. IPV can affect individual victims, their children, third parties, and society as a whole in different ways. According to Campbell (2002), research indicates that the level of IPV, as well as its regularity and ruthlessness, influence the impact on the victim with more severe, more frequent IPV increasing the impact. The NISVS found that a lifetime of IPV caused 18.8% of women to report at least one IPV-related impact (measured by the survey). The highest percentage, 25.7% of women, stated being fearful, while 10% stated missing at least one day of work or school as a result of IPV. One-point five percent of women contracted a sexually transmitted disease (STD) and 1.7% stated that they became pregnant after being sexually penetrated by an intimate (Black et al 2010). Black et al (2010) further indicated that only 19.2% of women who suffered IPV stated they experienced no IPV-related impacts.

Current research indicates that regardless of the expenditure of billions of dollars in the USA on healthcare every year, the country only ranks 27 out of 33 of the most developed countries in life expectancy at birth. According to the research, the depressing statistic is because of the high infant mortality associated with pre-term birth and low birth weight – outcomes that may be directly linked to IPV. Barbara et al (2013) citing Bloom (2011), revealed that women's health cannot merely be disentangled and addressed without thought given to women's

freedom from violence and their access to education, employment, finances, decision-making power, health services and other essential resources.

It was previously mentioned that IPV is a public health concern and has incalculable costs. It restricts a woman's progress, her productivity, her socio-economic roles and her psychological health (Esere et al 2009). IPV puts victims in jeopardy of getting sexually transmitted infections (STIs) such as HIV/AIDS, sustaining physical and emotional injuries, loss of self-esteem, eating disorders and the terror of being in the same dwelling with an abusive intimate partner. Below are some of the major consequences that face victims of IPV.

2.3.2.1 Physical consequences of intimate partner violence on women

There is no doubt that IPV affects women physically through direct pathways such as bruises and welts; lacerations and abrasions; abdominal or thoracic injuries; fractures and broken bones or teeth; sight and hearing damage; head injuries; attempted strangulation; and back and neck injuries. Moreover, and probably far more common, are ailments that habitually have no identifiable medical cause, or are difficult to diagnose. These are occasionally referred to as "functional disorders" or "stress-related illnesses" and include painful gastrointestinal symptoms, fibromyalgia, various chronic pain syndromes and exacerbation of asthma. A multi-country study conducted by the WHO (2005) revealed that the occurrence of injury among women who have been physically abused by their partners ranged from 19% in Ethiopia to 55% in Peru. Victimised women were also found to be twice as likely as non-victimised women to report poor health and physical and mental health difficulties, even if the violence occurred years before. Most victims suffer from injuries which frequently result from attacks by their intimate partners. According to Campbell (2002), physically abused women are more likely to have been injured in the head, face, neck, thorax, breasts and abdomen.

South Africa is not a country at war; however, it faces an exclusive burden of morbidity and mortality resulting from violence and injuries. These deaths and injuries are often a consequence of GBV, mainly IPV. Violence and injuries are the leading cause of death in the country. Seedat et al (2009:1011) argued that the general injury and death rate of 157,8 per 100 000 population is approximately twice the global average, and the rate of homicide of women by intimate partners is about six times the global average.

2.3.2.2 Psychological consequences of intimate partner violence on women

Lipsky and Caetano (2007) stated that IPV may have a considerable impact on the mental health of victims. In their examination, Lipsky and Caetano (2007) pointed out that the NVAWS in the USA estimated that almost 1.5 million of the 5.3 million rapes, physical assaults and stalking incidents perpetrated against women by intimate partners each year led to some type of mental health problem. IPV is also highly related to an increased likelihood of experiencing post-traumatic stress disorder (PTSD) (Sabina et al 2006). Furthermore, the authors stated that the rates of PTSD among women victimised by a partner ranged from 31% to 84% and the greater the regularity and severity of victimisation, the greater the likelihood of PTSD. Almost all forms of IPV, that is, physical, psychological, verbal and sexual, are strongly associated with PTSD.

According to Hanson (2002), the symptoms of post-traumatic stress include poor concentration, avoidance, hyperarousal and lack of motivation and energy, and are common reactions to partner violence. Campbell (2002) argued that a comprehensive meta-analysis of research done in the USA indicated that the risk of depression and PTSD stemming from IPV was even greater than that resulting from childhood sexual assault. Depression in women experiencing IPV has also been linked with other life stressors that frequently result in domestic violence such as a change in residence, having many children, forced sexual intercourse with an intimate partner, separation, child behaviour problems and marital separation (Campbell 2002).

2.3.2.3 Socio-economic consequences of intimate partner violence on women

The WHO (2010) claimed that IPV has major adverse costs to the economy; for instance, in the UK, one analysis estimated that IPV's yearly cost to the economy in England and Wales was roughly £22.9 billion. These costs emanated from the health and legal services provided to victims of IPV. Such services comprised the treatment of injuries rendered at hospital and physician services. It was further stated that some women took time off from work which also negatively impacted the economy of their countries in different ways. The WHO (2010) noted that when the costs associated with individuals not reaching their full productive potential are factored in, the overall costs to society will be even higher.

2.3.2.4 Sexual and reproductive consequences of intimate partner violence on women

IPV might lead to a host of harmful sexual and reproductive health consequences for women such as an unplanned and undesirable pregnancy, abortion and unsafe abortion, STIs including HIV, pregnancy complications, pelvic inflammatory disease, urinary tract infections and sexual dysfunction. IPV can impact directly on women's sexual reproductive health rights through forced sexual intercourse within matrimony leading to infections or through indirect means, for instance, making it difficult for women to negotiate contraceptive or condom use with their partner. Jewkes et al (2010) confirmed that IPV prevents women from influencing the circumstances of sex, resulting in more frequent sex and less condom use. Women who experience IPV, especially sexual abuse, suffer among other health consequences, gynaecological difficulties due primarily to physical abuse and forced and unprotected sex by an intimate partner. Physically abused women suffer gynaecologically more than non-abused women (Campbell 2002:1332). According to Campbell (2002), the symptoms and conditions consist of STDs, vaginal bleeding or infection, fibroids, decreased sexual desire, genital irritation, pain on intercourse, chronic pelvic pain, and urinary tract infections.

2.3.2.5 Health consequences of intimate partner violence on women

The health consequences of IPV are both wide-ranging and significant with experience of IPV being meaningfully associated with self-reported poor health (Ellsberg et al 2008) and an important cause for loss of disability-adjusted life years (DALYs) (Krug et al 2002). Common health impacts of IPV include the following: acute injuries (Sheridan & Nash 2007), chronic diseases (Campbell 2002), gynaecological problems (McCauley et al 1995) and homicide (Stockl et al 2013). The physical effects of HIV could manifest only sometime after transmission.

Generally, the injuries, fear and stress linked with IPV above may lead to severe health problems such as chronic pain, including headaches, back pain, fainting and seizures. IPV is thus observed as a major public health concern (Campbell 2002). As IPV is perceived as one of the greatest barriers to ending the subordination of women and a factor responsible for the infection of many women with HIV, we are still to witness the increase of new HIV infections if IPV is not successfully dealt with. Due to the dread of violence, women are unable to refuse sex or negotiate safer sexual practices thus increasing their vulnerability to HIV if their

husbands are unfaithful (Uthman 2009). Studies demonstrate that women's vulnerability to HIV is heightened by experiences of physical violence by their intimate partners (Jewkes et al 2010 and Ferdinand 2009:14). Africa is the epicentre of HIV prevalence and this continent also bears much of the burden of IPV. As both IPV and HIV have strong connotations, a large proportion of African women are likely experiencing the burden of these two public social issues concurrently.

A case study in Nairobi, Kenya revealed that women who were visiting an STI clinic and were living with HIV/AIDS reported a high lifetime prevalence of violence in their intimate relationships (Jewkes et al 2010). While the use of alcohol is one of the often-cited factors responsible for the perpetration of violence, experiencing IPV is also associated with drinking problems among people who are victims of such abuse. Rodriguez et al (2008) claimed that IPV is linked with adverse health behaviours such as alcohol abuse and smoking.

The harmful consequences and problems associated with IPV often continue to be felt by the majority of victims of IPV after they leave an abusive relationship. Ford-Gilboe et al (2009) revealed that post-IPV continues to exert direct negative effects on women's mental and physical health for a typical period of 20 months after leaving abusive relationships and that the extent of these effects depends on the brutality of the abuse.

2.4 INTIMATE PARTNER VIOLENCE AGAINST MEN

We need to comprehend that while the degree of violence directed at women is high, we cannot overlook the fact that men also experience violence directed against them by female partners. Research proposes that although IPV impacts on women and data from more than 100 surveys of family problems and conflicts indicate that women can be as physically aggressive, or more aggressive, than men in their relationships (Ansara & Indin 2009; Fincham et al 2008:260). Wong et al (2008) stated that partner violence against women has received notable attention in South Africa but little research has been conducted on the experiences of men. One may argue that a proportion of the violence experienced by male partners may be a direct result of women attempting to defend themselves (WHO 2010).

There is evidence that women's use of violence against their male partners has existed since the 1970s when IPV began to be systematically examined. Since then, there has been an

intensification in IPV with men as the victims. There are, however, hardly any intervention programmes intended to deal with such a situation. Far fewer researchers have examined men concerning their IPV victimisation. Mechem et al (1999) discovered in their investigations of emergency departments (EDs) that almost 13% of male patients surveyed reported IPV victimisation by female partners within the past year. Furthermore, 37% of the IPV incidents involved weapons. Government departments and non-profit organisations spend huge amounts of money every year to combat IPV. However, this spending goes to campaigns against the abuse of women, girls and children. It is unlikely that a percentage of this spending is devoted to campaigns for IPV against men. The South African government pays attention to violence against women and children (VAWC) but sadly there are also men and boys out there experiencing abuse and not much is being done about it.

Researchers have recognised that women are more likely to be battered and to involve law enforcement such as police for IPV attacks than men (Phelan et al 2005). In contrast, Lipsky et al (2004) in a study of female perpetration in an ED context, found that 56% of women partners who had been abused in the past year also acknowledged perpetration behaviour. Women who sanctioned perpetration behaviours in the study were more likely to be African American and engage in alcohol and drug abuse. Kernesmith (2005) discovered that female perpetrators were more likely to use violence in response to prior abuse than male partners. LifeLine Pietermaritzburg (2017) acknowledged the incidence of IPV against male partners but pointed out that the prevalence of such violence is unknown due to under-reporting. South African law enforcement and the justice system are so focused on VAWC that men who report violence are likely to be convicted if they report abuse. As a result, under-reporting occurs.

If the perpetration of violence by women partners is originating from their exposure to violence by their male partners, it is a necessity that effective ways are found for them to deal with their anger in a non-violent manner.

2.5 PREVALENCE OF INTIMATE PARTNER VIOLENCE

2.5.1 Prevalence of intimate partner violence: Globally

IPV is a widespread and devastating societal challenge. It is a global phenomenon and, in the USA, more than 1.5 million women are beaten by their partners each year and estimates are

that as many as one-third of all women will be physically assaulted by a partner during their adulthood (Gollan 2014:337). Most disturbingly, women are more likely to be killed by their male partners than any other category of the perpetrator (Gollan 2014). Over and beyond the direct and awful physical trauma to women, spousal abuse also has serious psychological and emotional consequences, including PTSD, depression and low self-esteem. In 2013, the WHO issued a systematic review of the prevalence and health effects of both physical and sexual IPV abuse (WHO 2013). It was found that almost 30% of all women who had been in a relationship had experienced sexual and physical violence by their intimate partner. The prevalence estimates of IPV ranged from 23.2% in high-income countries and 24.6% in the WHO Western Pacific region to 37% in the WHO Eastern Mediterranean region and 37.7% in the WHO South-East Asia region. Internationally, almost one-third of women do face IPV perpetrated by their male partners or, at times, by their ex-partners at a certain point in their life and as many as 38% of all homicides of women are committed by intimate partners. Moreover, 7% of women globally have reported being sexually assaulted by someone other than a partner, although data for non-partner sexual violence are more limited. The prevalence of IPV (both physical and sexual) is highest in the central sub-Saharan Africa region (65.64%). In contrast, the lowest reported prevalence is in East Asia (China and North Korea) at 16.3%. In other WHO regions, between one-quarter and one-fifth of women have experienced physical or sexual violence from a partner: Western Europe (19.3%), North America (21.3%), Central Asia (22.9%) and Southern Latin America (23.7%). All remaining Global Burden of Disease regions have a prevalence of over 26%.

The WHO's (2005) multi-country study on women's health and domestic violence against women, one of the few studies to include comparative data, found that 15% of women in Japan and 71% of women in Ethiopia mentioned that they had experienced physical and sexual abuse by an intimate partner in their lifetime. Furthermore, 3.8% of Japanese and 53% of Ethiopian women reported witnessing such abuse within the past year. A survey conducted in Canada of 24 000 men and women revealed that 7% of the women and 6% of the men openly stated that they had been victims of IPV in the last five years (WHO 2005). According to Lasern et al (2005), IPV is a worldwide human rights issue as well as a health problem. The authors found that a lifetime prevalence of IPV among women ranged from 15% to 71%. Similarly, Gupta et al (2008) found that global estimates of IPV show that 15% to 75% of women have experienced such violence.

Smith et al (2004) indicated that adolescence (ages 14-18 years) was a predominantly risky period for dating violence. In a 2003 study, the authors (Smith et al 2003) discovered that 69.7% of girls in grades nine through 12 reported being "beaten up" by a boyfriend and 21.3% reported being sexually abused. A study on adolescent health behaviour in the USA found that 32% of women who had been in heterosexual relationships had been either emotionally or physically abused by their partner (Flisher et al 2007). Furthermore, Ramissetty-Mikler et al (2006) reported that topical studies estimated that 28% to 96% of young adults were victims or survivors of IPV. IPV is also prevalent among young adults attending colleges and universities. A significant number of high school and college students witness innumerable forms and levels of violence in their dating relationships. Simons et al (1998) confirmed that 1% to 3% of college students reported that they had experienced severe forms of abuse such as beatings with an object. Ramisetty-Mikler et al (2006) found that one in three high school and college students had experienced sexual, physical, verbal and emotional violence while in a relationship. A study conducted in Ethiopia revealed that nearly 16% of 1 378 male college students reported physically abusing an intimate partner or non-partner, and 16.9% reported committing acts of sexual violence (WHO 2010).

When examining the results shown by these studies on IPV among youth, one may argue that a majority of young people start facing partner violence at an early age, long before they attend a university or college. By the time they reach tertiary-level studies they have already faced at least one episode of IPV. Rodriguez et al (2004) stated that in the USA alone at least 1.5 million women are physically, emotionally or sexually abused by their partners each year.

A topical study on violence against women published by the European Union Agency for Fundamental Rights (FRA) (2014) affords greater clarity. The study was based on interviews with a randomised sample of 42 000 women aged between 18 and 74 years from across the 28 member states of the European Union (EU). A minimum of 1 500 women were interviewed from each EU state, except for Luxembourg where 908 women were interviewed. The findings of this research recommended that the experience of abuse is widespread but systematically under-reported throughout the EU, distressing the lives of many women. It was found that there is a strong correlation between the levels of partner and non-partner violence within a country. Of note, the member states scoring higher on the gender equality index tended to have a higher prevalence of IPV.

Studies conducted in Bangladesh have revealed that more than 40% of women testified that they have experienced a form of physical violence in their intimate relations (Koenig et al, 2003; NIPORT 2009). A study of women in six villages in Bangladesh conducted in 2001 and 2002 revealed that 35% of the women were violated at the hands of their husbands in the past year, and 67% of women had been exposed to domestic violence at some point in their lives (Bates et al 2004). Furthermore, between 42% and 47% of women in Bangladesh have experienced physical violence during pregnancy (Khan et al 2011). These findings show that most married women in Bangladesh, particularly those with disabilities, are at increased risk of IPV. The lifetime occurrence of any form of violence (physical, emotional or sexual) was found to be 84% among a sample of 226 women with disabilities selected from four districts in Bangladesh (Hasan et al 2014). A study conducted in 29 states in India revealed that 37% of women face violence in their intimate relations and occurrence rates were comparatively higher in urban areas as opposed to less developed, remote villages (Ministry of Health and Family Welfare 2007). Researchers such as Das et al (2013), Ruika and Pratinidhi (2008) and Sinha et al (2012) showed that prevalence rates for IPV against women in India range between 35% and 60%. According to Chokkanathan (2012) and Esquivel-Santoveña et al (2013), 12% of women reported psychological victimisation and verbal abuse in the past year. Furthermore, between 22% and 28% of women in India endure physical beatings during pregnancy at the hands of their husbands (Das et al 2013).

2.5.2 Prevalence of intimate partner violence in Africa and sub-Saharan Africa

The systematic assessment of IPV in Africa done by Shamu et al (2011) indicated that the prevalence of IPV in Africa ranges from 27.7% - 51.1%. The study reviewed literature from Nigeria, Zimbabwe, South Africa and Rwanda. The Zambia Demographic Health Survey (2000), reported that approximately 80% of Zambian wives found it tolerable to be battered by their husbands as a form of chastisement. This tolerance is a crucial factor in determining the level of persecution. Of the 529 women that were interviewed countrywide, 79% said they should be beaten if they went out without their husband's permission, 61% said they should be beaten if they denied their husband sex, while 45% said a beating was in order if they cooked bad food for their husbands.

Six prominent, nationally representative studies conducted in Malawi presented incidence rates for numerous forms of GBV amongst women and children. The most cited and major of these

studies are the two Malawi Demographic and Health Surveys (MDHS) that were subsidised by USAID and conducted by the National Statistical Office (NSO) of Malawi in 2004 with ORC and in 2010 with ICF Macro (NSO and ORC Macro 2005; NSO and ICF Macro 2011).

In Ethiopia, IPV against women is widely recognised to be of great concern, not just from a human rights perspective, but also from an economic and health viewpoint. The government of Ethiopia revised its family law in 2000 and its criminal law and constitution in 2005 to safeguard and assure the rights of women and children and to endorse gender equality and equity. It has been acknowledged that IPV affects all the domains of women's lives such as self-esteem, productivity, independence, capacity to care for themselves and their children, ability to participate in social activities, and even death (Garcia-Moreno, et al 2005 and Pourasadi, et al 2012). Notwithstanding the international emphasis to reduce IPV against women, the extent of IPV in Ethiopia is very high.

The Demographic and Health Survey conducted in Egypt for the year 2005 found occurrence rates of IPV to be as high as 47% and the most common perpetrators were current or previous husbands (El-Zanaty & Way 2006). A cross-sectional survey of 5 230 male and female participants in Egypt revealed that 30% of men admitted to committing violence against their wives and 41% of women reported that they had been the victims of physical IPV (Almosaed 2004). According to the Amnesty International report of 2007, approximately 250 women were killed by their intimate partners in Egypt. A review of newspaper reports in that country showed that most women are murdered because of doubts about illegitimate relations, and in 41% of cases, the murderer was the husband (Palvia et al 2003).

Comparable patterns to Egypt are evident in Turkey and Palestine (Kulwicki 2002) and oftentimes the perpetrators are excused from punishment under the patrilineal norms of female-male sexual behaviour. IPV against women is also extremely predominant in Tunisia (Douki et al 2003). A survey conducted in Saudi Arabia found that 53% of men who committed physical abuse against their wives vindicated their violence on the basis that they have a right to control their wives' behaviour (Almosaed 2004).

McCloskey et al (2005) claimed that the prevalence of IPV in sub-Saharan Africa is extreme when compared with other developing regions globally. For example, they noted that in Zambia 48% of married women have experienced some form of IPV in their lifetime. According to the

WHO (2013) and the London School of Hygiene and Tropical Medicine, the worst affected WHO regions (based on countries with available data) concerning lifetime IPV experience are South-east Asia (37.7%), Eastern Mediterranean (37%) and Africa (36.6%). When the WHO (2013) combined the prevalence of IPV and non-partner sexual violence Africa, at 45.6%, displayed a higher burden followed by South-east Asia (40.2%), Americas (36.1%), high-income countries (32.7%), Western Pacific (27.9%) and Europe (27.2%).

The conditions in Ghana are not very different from those reported for the entire African region. Coker-Appiah and Cusack (1999) reported that one in three Ghanaian women experienced physical abuse by male partners in their lifetime. The reports from the 2008 Ghana Demographic and Health Survey (GDHS) (2008) showed that 38.7% of married women surveyed had faced or experienced either sexual, physical or emotional (or all three) forms of violence from a husband/partner in their lifetime.

Research targeting young people has revealed that even high school students are at risk of IPV. Lawoko (2006), for example, claimed that Zambian women start experiencing IPV as early as 15 years old. According to Matud (2007), IPV arises between couples of all ages but it appears to occur more frequently in younger couples. Moreover, those between the ages of 15 and 19 years are at a higher risk of suffering physical and sexual violence by their intimate partners in most countries.

2.5.3 Prevalence of intimate partner violence in South Africa

South Africa demonstrates a unique situation from a political perspective, particularly concerning apartheid. It has been argued that the legacy of apartheid has left South Africa with a "culture of violence" that makes violence a normative rather than a deviant behaviour and is thus regarded as an appropriate means of resolving social, political and even domestic conflict. One can argue that the country has become habituated to news headlines about IPV, be it physical assault, sexual harassment, rape, gang rape, corrective rape or murder. The perpetrators of IPV cut across racial and colour lines, socio-economic standing and educational background. In addition, the Legal Resource Foundation (2001) and Bott et al (2005) pointed out that the majority of South African women are illiterate and poor; hence, they do not know their rights are protected by the constitution and, therefore, they do not know they have the right to challenge the violence from their intimate partners. Martin et al (2002) stated that

Indian men if educated, are less likely to consider IPV acceptable. Vincent et al (2000) correctly argued that the impact of IPV is broad and substantial, with serious consequences not only for the women who are victimised but also for their children and society at large.

As described above, South Africa is not the only country with high levels of IPV. As witnessed in other parts of the world, the trends and occurrence of lifetime exposure to IPV are higher among South African women than men. Gupta et al (2008) found that more than 27.5% of South African men reported having committed physical violence against their most recent intimate female partner. McCloskey et al (2005) argued that nearly one in 10 women in South Africa testified having been exposed to violence in the previous 12 months, while 25% reported lifetime exposure to violence by an intimate partner. The South African Department of Justice reported that approximately 25% of South African women have been victims of IPV. Additionally, violence against women in post-apartheid South Africa has been noted as one of the country's most prominent features (Wong et al 2008). According to Wong et al (2008), 27% of women who lived in the Eastern Cape, 28% of women in Mpumalanga and 19% of women in Limpopo, conveyed that they were physically assaulted in their lifetime by a current or former partner.

IPV against women is normalised in many South African cultures (Collins 2013). Many South Africans have been raised in patriarchal cultures where their gender expectations may be in direct conflict with those encouraged in institutions of higher learning (Barkhuizen 2013). The focus in patriarchal cultures is on the broad societal factors that assist in generating a climate in which violence is fortified. This includes the receptiveness of the criminal justice system, social and traditional norms concerning gender roles or parent-child relationships, income inequality, the strength of the social welfare system, the social tolerability of violence, the availability of firearms, the exposure to violence in the mass media, and political instability (Barkhuizen 2013). For instance, the conservation and perpetuation of patriarchal values and behaviours in communities are a foremost cause of IPV. According to Jewkes et al (1999), one in five women in the Eastern Cape find violence against women to be tolerable. They believe that a woman must be submissive to her man, must be reprimanded by him, that the man has ownership of the woman, is entitled to sex and that beating is interpreted as a sign of love (Jewkes et al 1999). This acceptance may be a result of families or communities emphasising the significance of the maintenance of the male-female union at all costs or, alternatively, minimal legislation to safeguard women (Jewkes 2002). The gender roles conveyed from a

young age in South Africa support male dominance and female subordination, making young women more inclined to victimisation (Barkhuizen 2013). Economic difficulties are another aspect that makes women common targets of atypical gender behaviour with them being victimised more often than men (Iliyasu et al 2011; Gordon & Collins 2013). The national crime victimisation survey has shown that the highest number of physical and sexual assaults were perpetrated against younger women (Shibusawa & Sormanti 2008). In Shibusawa and Sormanti's (2008) review of the literature, the WHO (2010) observed that in one South African study of 928 males and females aged 13 to 23 years, it was found that 42% of the females and 38% of the males reported being a victim of physical dating violence at some point in their lives.

2.5.4 Prevalence of intimate partner violence in KwaZulu-Natal

A review of studies conducted in Africa found IPV prevalence during pregnancy ranging from 2% to 57%, with a meta-analysis estimating an overall prevalence of 15.23% which included physical, sexual and emotional violence (Shamu et at 2011). In a clinic setting in Durban, KZN 5.2% of women in antenatal care had experienced physical and/or sexual IPV in the past year (Groves et al 2014). This is arguably a relatively low rate of reporting given the extensive prevalence of IPV in South Africa (Jewkes et al 2002; Gender Links 2011) where population-based studies demonstrated a lifetime physical IPV-victimisation prevalence of 33% and a past-year prevalence of 13% (Machisa et al 2011).

A study done by the Medical Research Council (MRC) in three provinces of South Africa, including KZN, found that one in four women among general inhabitants had experienced physical abuse at some point in their life (Jewkes et al 2002). Similarly, a study conducted in 2013 by Gender Links in four provinces of South Africa, also including KZN, revealed that all the participants had experienced some form of violence, be it emotional, economic, physical or sexual at least once in their lifetime both within and outside their intimate relationships (Machisa et al 2011). The same report argued that a large proportion (41%) of men in KZN admitted to perpetrating some form of violence against women in their lifetime (Machisa et al 201). Another study conducted in rural KZN revealed prevalent patriarchal behaviours – adolescents' boys aged between 12 and 17 years were allegedly socialised from an early age into traditional patriarchal notions of masculinity. There is a strong belief that boys and men are incapable of controlling their sexual urges and that accountability for this control lay with

women and girls. Sexual violence was, therefore, understood as a strategy used by boys and men to put girls and women, if they became too autonomous and assertive, in their place (Peter et al 2003). Controlling behaviour by intimate partners which in itself may be an individual as well as a relationship-level factor is one of the drivers of IPV, intensifying the vulnerability of women to IPV in male-dominated family structures and social orders. As a consequence, it is not surprising that women can be tolerant of such control and may even rationalise it. Women's endurance of such acts of violence is an effect of the deeply-rooted socio-cultural norms and practices within the society.

According to Machisa et al (2011), the *ukuthwala* culture perseveres in KZN and has been recognised as one of the drivers of IPV and HIV. However, it remains of paramount significance to differentiate between *ukuthwala* in its traditional form and the harmful and somewhat distorted practice currently taking place in South African society. Mwambene and Sloth-Nielson (2011:6-7) argued that the first form of *ukuthwala* is where the girl is cognisant of her abduction being planned by her suitor. The different parties are in collusion with one another and the "force" used serves as a veil for the girl's implicit consent. Secondly, *ukuthwala* can occur where the families agree on the anticipated marriage but the girl is unaware of such an agreement. Mwambene and Sloth-Nielson (2011) argued that this type of *ukuthwala* might transpire in a situation where the girl possibly opposes her parent's decision or where she attracts no suitors, even though she might be of high rank. After the girl's *ukuthwala* and the endorsement of both families for the expected marriage, the girl is watched until she gets used to the idea of marriage. With regards to this form of *ukuthwala*, Mwambene and Sloth-Nielson (2011:7) confirm that "consent, as understood in Western terms (that is, the consent of the bride and bridegroom only), might be more difficult to argue here." The third form of *ukuthwala* as proposed by Mwambene and Sloth-Nielson (2011:7), happens against the will of the girl. She is taken by force to the young man's family home after which lobola representatives are sent to the girl's family to start marriage negotiations. This third form of *ukuthwala* can lead to crimes such as rape and intimidation as well as various human rights violations such as the infringement of the girl's liberty dignity and bodily integrity. This is one common type of GBV in KZN that is carried out under the guise of culture and the pretence of love.

2.5.5 Prevalence of intimate partner violence in Msinga

The extensive history of communal violence going back to the late 19th century has resulted in unique and complex institutions and behaviours that have influenced gender relations in Msinga. Hostility in Msinga appears to have started mainly between four groups: The Thembu, the Chunu, the Qamu and the Bomvu (Clegg 1979). Msinga had to absorb Black people who had been forced to relocate there due to colonial and apartheid laws making it legal for Blacks to be dispossessed of land in White-designated areas (Clegg 1979). Subsequently, this led to overpopulation, compromised agricultural areas and general land hunger which drove the inter- and intra-communal conflict in Msinga. Women and girls are particularly vulnerable to land dispossession as they are affected by both historical Black land dispossession and so-called cultural reasons for male ownership of land (Mnisi 2013). The conflict appears to have consisted of private wars between families, violence between different political parties and taxi violence. Bonnin (1997) stated that sexual violence was also a feature of the conflicts in Msinga and the political party violence in KZN more generally. It is hard to determine exactly when the main fighting ended. With large supplies of illegal firearms still in circulation in the region, outbreaks of violence still happen and communities remain somewhat militarised and battle-ready. Mthembu (1994) has stated the following about young men in Msinga: "Their built-in culture of fighting has taught them to look down on any man who does not possess a gun" adding that "such a man is derogatorily referred to as a woman."

By and large women in Msinga have retained their traditional existence and have acknowledged its underpinning patriarchal values. They epitomise the positive characteristics of traditional lifestyles described by Nyasani (1997), namely, hospitality, friendliness, consensus and a common framework-seeking principle, ubuntu and an emphasis on community rather than the individual. According to Siqwana-Ndulo (2013), society also makes it problematic for women to proclaim their individual rights. Siqwana-Ndulo (2013) argued that at one level provisions are made in the Constitution for enhancing the protection of women's rights and the attainment of equality. At another level, the Constitution endorses the right of traditional authorities to apply customary law which, in effect, makes provision for a parallel justice system that embeds customary practices that discriminate, in particular, against women. This is further deep-rooted by local government's implicit support for customary practices, such as providing funding for girls from the area to attend the annual Umkhosi Womhlanga or Royal Reed Festival at King Zwelithini's Palace in Nongoma.

In a nutshell, the scarce livelihood opportunities (particularly since most of the land is inarable), the low levels of education, the longstanding communal conflict, the customary or traditional values and the contradictory legislation make women and young girls in Msinga more vulnerable to being demoralised and their rights being violated. They also draw attention to the complexity of gender relations, the abject conditions of the women in Msinga and the difficult task IPV service providers have set themselves through their intervention programmes. It should be noted that the Msinga intervention programmes also require more resources due to the mountainous terrain and infrastructure backlogs in the area.

2.6 INTERVENTION PROGRAMMES DEALING WITH INTIMATE PARTNER VIOLENCE

2.6.1. Intervention programmes dealing with intimate partner violence: Globally

The NICE (2013) and Guy et al (2014) confirmed that the evidence on the efficiency of primary prevention programmes for young people is slight. Over the years, numerous researchers such as Jewkes et al (2014), Spangaro et al (2013) and Wathen and MacMillan (2003) have conducted reviews to evaluate what works in preventing IPV. Although their methods differed their assessments were in agreement that the evidence on IPVprimary prevention programmes is limited. Overwhelmingly, the research on IPV is skewed towards the more developed countries, particulary the USA, with a huge amount of research having being done or piloted in colleges, universities and schools. More research is needed from underveloped and developing countries to enhance our knowledge on how programmes can efficiently diminish incidents of IPV and how perceptions as well as behaviours perpetuate violence. It would be ideal in moving forward that findings derived from these studies as well as other assessments be extensively cascaded to ensure that researchers are not replicating work or encouraging harmful services that would promote unintentional costs.

Many remarkable efforts have been made over the past few years to combat IPV, particularly against women and girls and particularly focusing on the violence perpetuated in heterosexual relationships by men partners. It is noted that a large amount of work in fighting IPV has been concentrated on offering legal as well as health responses to survivors of IPV. Nonetheless, more recent studies on IPV prevention programmes are beginning to emphasise the importance

of encouraging participation of communities through community mobilisation and programmes which do so seem to be effective. According to Heise and Kostadam (2015), by concentrating explicitly on IPV, service providers establish contact with the family to start addressing the harmful societal customs, traits as well as behaviours that trigger various kinds of violence against women and girls (VAWG). Although the various kinds of VAWG have comparable features and fundamental endangering elements, combating IPV necessitates that service providers develop robust, evidence-informed and tailor-made guidelines that can be utilised when responding to the various kinds of forms of VAWG.

A variety of programmes have been shown to have positive outcomes for women experiencing IPV. According to Scott (2015), a diverse range of skill-building, counselling and therapeutic interventions can advance a range of outcomes that can include reduced rates of IPV, increased safety, improved mental health and wellbeing, improved pregnancy and child outcomes, and increased access to community resources. Several studies conducted included samples of women recruited from shelters who were already accessing the necessary support.

In 2002 the WHO Global Campaign for Violence Prevention was launched. This campaign aimed at raising international awareness about issues of abuse, the role of public health in its prevention and the increase in violence prevention programmes internationally, nationally and provincially. International policy on IPV including, in particular, the Declaration on the Elimination of Violence Towards Women, was adopted by the United Nations (UN) General Assembly in December 1993. This declaration raised awareness of the problem of abuse perpetrated against women globally, emphasised that errand states convict and eradicate all forms of abuse towards women, and highlighted the core strategies for prevention.

Picon et al (2017) conducted a significant study on IPV prevention in which they collected information on impact evaluations that measure the effects of international development policies and programmes. According to Picon et al (2017), the US Agency for International Development (USAID) evaluated the implementation of its global GBV strategy in 2015 and 2016 and the Department for International Development (DfID) published an independent review of its work in addressing VAWG. The focus was mainly on developing an evidence gap map (EGM) which ascertained what works and what does not work in programmes preventing VAWG. The Inter-American Development Bank has funded pilot programmes and scaled-up initiatives such as Ciudad Mujer, True Love, and the adaptation of the IMAGE programme in

Peru. There are undeniably transformations in the way certain interventions are organised in the various reviews. Fulu and Kerr-Wilson (2015), for example, systematised school-level curricular changes pertinent to IPV prevention as institutional-level interventions. Picon et al (2017) talked highly of the SASA, WINGS and SHARE programmes in Uganda that present remarkable prevention opportunities. In India, there has been augmented interest in tackling GBV in the past few years, particularly since the Delhi rape events of late 2012 which were widely discussed by the media, the government and donors.

Scott (2015) argued that most interventions focus on young people and are aimed at preventing violence or abuse before it occurs. However, the key point in time for the effective delivery of primary preventative interventions remains to be identified. Scott (2015) further mentioned that interventions intended for adults have tended to be media or awareness-based campaigns but the evidence for these is inconsistent as some interventions have been effective while others have not. Supplementary evidence on the effectiveness of IPV programmes with various populations experiencing IPV is desirable as is evidence on programmes tailored to women from specific equality groups, such as those with disabilities and/or from ethnic minorities.

2.6.1.1 Police and justice sector programmes

2.6.1.1.1 Police and security personnel training and capacity building

Jewkes (2014) suggested that capacity building initiatives as well as training courses for law enforcement agencies primarily intend to create awareness, improve ability and build capacity to address VAWG. Capacity building for law enforcement agencies involves giving them knowledge and facts on the forms of and the reasons for VAWG; the accessibility of resources available for survivors; and the needs of the survivors, including how to ensure that survivors do not experience secondary victimisation. Jewkes (2014) argued that the training of police and security personnel aims at encouraging transformation through developing interpersonal as well as communication skills, dealing with stress and anger management, and improving attitudes towards women. Further training objectives include the development of "skills to manage investigations and conduct risk reduction and prevention activities, including implementing response protocols, investigating incidents, gathering evidence conducting interviews, understanding risk assessment and managing cases" (Jewkes 2014).

Jewkes (2014) contended that police training and capacity building programmes are widely implemented but infrequently evaluated as not even one study assessing capacity building and training courses' effects on minimising issues of IPV was identified. According to Khalique et al (2010) and the UNFPA (2008), there is very little evidence available suggesting that capacity building courses might bring about a modification in the attitudes and behaviours of law enforcement agencies and that these agencies might have improved trustworthiness amongst the survivors of abuse.

Authors like Heise (2011) and Khalique et al (2010) claimed that law enforcement courses are habitually carried out as "one-off" occasions without any refresher courses. The lack of training within the law enforcement agencies is identified as a major challenge because police personnel regularly switch positions as Khalique et al (2010) confirmed in their assessment of the training course offered to law enforcement in Pakistan. It is also noted that training programmes are often carried out by trainers that do not possess the necessary knowledge, skills and values held by law enforcements and thus, according to Heise (2011), are more likely to be temporarily tolerated and indulged rather than treated as legitimate agents of long-term change. The result is that many training courses for police officers fail to accomplish their desired objectives.

2.6.1.1.2 Community policing

The term "community policing" has no clear definition. However, it can involve police departments organising their management, structure, personnel and information systems in a way that supports partnerships with women advocates, traditional and community leaders and other community members to enable proactive problem-solving focused on survivor safety (Jewkes 2014).

No studies assessing the impact of community policing on reducing IPV, particularly against women, have been identified. Hence, there is no evidence that community policing encourages increased involvement by IPV survivors with the judicial system procedures or increased partnerships between law enforcers and members of the community. Research conducted by Robinson and Chandek (2000) investigated if police police officers functioning under a community policing mandate were able to maintain the involvement of victims in the judicial system procedures. They found that law enforcement had no impact on influencing the increased involvement of victims in the judicial system procedures.

Studies have shown that community policing plays an important role in police-community partnerships. Research conducted on the New Delhi Police's Parivartan Programme by Marhia (2012,) suggested that community-based policing increases the commitment of women with regard to community activities and increases information sharing within the police departments. In the programme women safety committees comprising women members of the police force conducted door-to-door campaigns in underdeveloped residential areas aound New Delhi. They provided relevant literature on the scourge of GBV including IPV as well as on sexual abuse which was prevalent in the area.

2.6.1.1.3 Women's police stations

Women's police stations (WPS) are a slight contradiction. These stations are by and large said to mainly attend to women and are usually "manned" but not exclusively so, by women law enforcement officers. Their focus is on women and they provide specific services to the survivors of IPV, domestic violence and rape (Jewkes 2014). These police stations do awareness campaigns in sensitising people about these issues, offer assistance in getting legal advice (such as applying for court restraining orders), generic counselling, financial assistance and healthcare. They were first established in Brazil in 1985 and exist throughout Latin America as well as in other countries such as South Africa (where men police officers are also employed), India, Liberia, Ghana, Uganda, Kosovo, Liberia, the Philippines and Sierra Leone. Brazil has approximately 475 WPS. The WPS in Sierra and Peru are only mandated to address issues of domestic violence including IPV. However, the WPS in countries such as South Africa, Brazil, Argentina and Nicaragua also take cases of non-spousal abuse (Jewkes 2014).

No studies specifically measuring the impact of WPS on the occurrence of IPV were found. Studies on WPS mainly concentrated on comprehending the experiences of women when accessing the stations. Thus, there is no evidence that the WPS provide timeous and efficient services to women survivors and that their services result in an increased conviction of offenders. However, it has been confirmed that WPS do result in an increase in the reporting of cases of violence by women survivors who are able to access needed services. According to Heise (2011) and Jubb et al (2010), the effectiveness of WPS is based on their providing an entry point to the judicial system. Jubb et al (2010) argued that the WPS in certain areas have significantly sensitised people on issues of VAWG, representing it as a collective and public

issue as well as one requiring legal intervention. The stations have also improved the referral systems, justice measures and women's access to safety. The increase in women's exercise of their human rights and knowledge as a result of the WPS was also noted.

A WPS study (Natarajan 2005) conducted in Tamil Nadu interviewed 60 dowry victims. The study found that for just under 50% of the women IPV had decreased and the majority of the women alleged that the decrease in IPV incidents was because of the services provided to them by the women law enforcers. However, 5% opined that the women police interference exacerbated their conditions. Natarajan (2005:102) stated, "… in many ways, the all-women police units (AWPUs) act as a surrogate village 'Panchayat' with the important difference that women police are in charge of resolving the dispute and they often serve as advocates for the women".

2.6.1.1.4 Specialised courts

Special tribunals, for instance, courts focused on sexual violation matters, have been created or established to fast track and cluster cases related to women abuse. Cook et al (2004) stated that the focus of these courts is to raise the conviction rates and have an understanding of victims or survivors and their immediate families. They also assess the efficiency of the legal system in addressing womens' issues and its coordination with other role players in the judicial system, as well as to decrease adjournments. Courts for sexual violation functioned in South Africa and Liberia while courts specialising in domestic violence matters have operated in parts of the UK, the USA and Canada for more than a decade.

Three studies focusing on specialised courts have been identified. However, according to Cook et al (2004), Gover et al (2003) and Sadan et al (2001), these studies were conducted in urban specialised courts located in well-developed states. It is noted that by and large these ad hoc courts have not been examined for their effect on lessening VAWG. Nonetheless, Spangaro et al (2013) found that special courts in humanitarian and post-conflict contexts were not associated with reduced risks or incidences of violence. Mischwski and Mlinarevic (2009) as cited from Spangaro et al (2013), stated that women in another study felt that the potential of being revictimised was lessened by partaking in a development where sexual abuse was emphasised to be immoral, and offenders of sexual abuse were held liable. However, Brouneus (2008) and Nowrojee (2005) argued that some researchers found that women survivors lacked

safety, were exposed to stigma, suffered social isolation and were subject to vengeance. Denov (2006) was of the view that most survivors of violence face difficulties when testifying in courts and the whole process is a stressful one. Finally, there were some indications of special courts having a positive influence on ensuring access to justice for the survivors of abuse.

Gover et al (2003) pointed out that a specialised court for domestic violence issues in South Carolina, USA discovered a significantly fewer number of cases of re-arrests amongst the perpetrators that served their sentences in prisons. Likewise, Sadan et al (2001) in a trial evaluation conducted in South Africa in 1999 with courts specialising in sexual crimes, found an increased rate of conviction in these of approximately 65% – almost double that of other "normal" courts of law. Furthermore, Cook et al (2004) in an assessment of five models of courts specialising in cases of domestic violence in Wales and England, found three significant positive effects, namely, improved efficiency by the courts in service delivery and support provided to victims of abuse; enhanced information-sharing and advocacy; and improved rates of clients' satisfication and of encouraging their involvement. A further positive effect noted was improved community confidence in the criminal jurisdictional branch.

2.6.1.1.5 Legal interventions

Legal interventions comprise the following: education on legal issues; services on legal aid; units of specialist prosecution or courts; summonses through the criminal courts that are international; training for judicial officials; and rights awareness (Spangaro et al 2013; IDLO 2013). Two comprehensive reviews concerned legal interventions (Spangaro et al 2013 & Morrison et al 2007). In addition, three studies (Griffen 2009; IRC 2012 and Sotirovic 2012) highlighted interventions employed in the USA, the UK and Tanzania as well as the international criminal courts of the former Yugoslavia and Rwanda.

There was, furthermore, evidence that survivors can find the process of testifying traumatic in their lives (Denov, 2006, cited in Spangaro et al 2013) and they would certainly require intensive therapeutic sessions. Morrison et al (2007) do not provide any evidence on the effect of judicial services in reducing violence. They do, however, highlight evidence which indicates that access to justice by survivors cannot be attained without a comprehensive improvement in the judicial system where issues such as the lack of transparency, fraud and unnecessary adjournments are addressed.

2.6.1.1.6 Paralegal training interventions

According to Jewkes (2014:14), "paralegal programmes usually focus on developing, training and institutionalising the work of community-based paralegals, whether in post-conflict, transitional or developing countries. Paralegals normally live and work in the communities they serve and use their knowledge of the formal justice system, and sometimes alternative mechanisms, to assist women in following legal cases after experiencing abuse". Furthermore, the IDLO (2013) identified other lawful interventions for communities that might or might not be employed together with or by paralegals themselselves such as providing legal education and legal aid services to women.

Some studies found that training paralegals or advocates show some promise in providing support to women in accessing the systems of justice as well as reducing short term re-abuse (Chibuta 2011, Bell & Goodman 200, Hester & Westmarland 2005). One randomised control trial (RCT) "of a legal advocacy programme in the USA which trained law school students to work intensively with women seeking protection orders" discovered at the six weeks follow up, "that women in the treatment group reported significantly less physical and psychological re-abuse and marginally better emotional support in comparison to women in the control group" (Bell & Goodman 2001:1398).

An assessment conducted in 2000 of 27 projects of domestic abuse employed throughout the UK discovered a significant improvement in the number of domestic abuse cases reported to police stations by women who had received uncompromised legal support especially when they were escorted to courts hearings. The provision of tailored legal advocacy to Black-African and traditionally marginalised women improved the women's involvement in the systems of criminal justice. It is critical for programmes that are legally-based to assist women to access the justice system starting from the process of investigation to their case prosecution.

Programmes to increase legal literacy and support women to cope with complex legal processes and plural legal systems are crucial in overcoming the blocks that constrain women's access to justice. Jewkes (2014) argued that women's legal rights organisations play a vital role in publicising domestic violence laws locally, disseminating and cascading information to aid

women to access their rights, and providing necessary advice and support to enable women to navigate legal processes.

Chibuta (2011) indicated in a study conducted with Tanzanian refugee women and girls that the effectivessness of the establishment of paralegal units and the realisation of paralegals' training had aided abused women to more easily access services from legal institutions than they were able to do before.

2.6.1.1.7 Protection orders

According to Jewkes (2014), evidence points to evidence indicating that court protection orders do, at times, decrease violent incidences for some survivors of abuse. However, levels of violence after the protection orders have been issued continue to be high. Researchers such as Carlson et al 1999, Holt et al 2003, Logan & Walker 2010 and McFarlane et al 2004 in their studies conducted in the USA reported levels of re-victimisation ranging from 23% to 70% after the issuing of court protection orders. A study by Spitzberg (2002), cited in Heise (2011) critically reviewed 32 evaluations and discovered that in general, 40% of court protection orders were dishonored.

According to Kelly et al (2013), a 2013 pilot study of court protection orders on domestic abuse cases in the UK employed a case matching method to evaluate their impact on the repetition of abuse. This pilot study revealed that, generally, there were 2.6 reduced recurrences of domestic abuse cases in those incidences where the court domestic protection orders were employed as opposed to 1.6 reduced occurrences where no further action was applied. Once the conviction was completed, there was a further decrease of one occurrence of domestic abuse for every survivor. Court protection orders of domestic violence thus seemed to be more effective in decreasing re-offences.

Some researchers have found that women whose safety has been promoted through being helped with protection orders show improved psychosocial effects. In this regard, Logan and Walker (2009) in one study in the USA discovered that most women after applying for court protection orders felt "safer" than before as 75% of them reported that the court protection orders were "extremely" (51%) or "fairly" (27%) effective in reducing violence in their homes. A majority of women recipients in the DVPO pilot study in the UK (referred to above) reported

that they felt protected and that the protection orders granted them some opportunity to consider their options. However, a study conducted in 2013 in the USA of 106 violated immigrant mothers who had access services of judicial systems or shelter discovered significant enhancements in the women wellbeing, resiliency and mental health irrespective of whether a court protection order was issued or not (Cesario et al 2014). According to Ko (2002), cited from Goodmark (2007:11) protection orders "interrupt the pattern of domination and control by directly restructuring the relationship level between the victim and abuser." Conversely, the review by Goodmark (2007) highlighted some problems associated with the over-reliance on protection orders. Where a woman with safety concerns cannot secure one, for instance, due to lack of legal representation or losing a hearing, she can be presumed to have not taken the required steps to protect her children and, as a result, can have child abuse or neglect proceedings started against her.

2.6.1.2 Crisis intervention

2.6.1.2.1 Hotlines

Bennet et al (2004) argued that telephone hotlines permit survivors of abuse and their friends and immediate family members to confide about their experiences of violence and also to get relevant knowledge on how to handle particular issues such as childcare or housing. According to Bennet et al (2004), hotlines are operated by both trained staff or volunteers who have undergone intervention crisis training and they usually function twenty-four hours and seven days a week.

Bennet et al (2004) discussed an assessment of a hotline providing various services such as therapeutic counselling, advocacy, and shelter across 54 programmes of domestic abuse in the state of Illinois in the USA. Survivors who phoned were provided with information on issues such as the different forms of abuse and the user statements showed that they felt more supported and were listened to. The effect of the hotline on violent incidences was not measured. It is noted with concern that hotlines in South Africa particularly for abuse against children like "Childline" and women are quite busy lines as high volume of callers utilise them. As a result, Cloete et al (2014) noted a considerable emotional disturbance on the part of clients when they are unable to receive immediate attention to their calls from the 24-hour service.

2.6.1.2.2 One-stop centres, sexual assault centres and other women's support centres

One-stop centres (OSCs) offer social, pschological, health and legal amenities in a single place, permitting speedy access to amenities for the survivors of abuse, thereby enabling them to avoid secondary victimisation. In other situations, OSCs also offer further courses and refresher courses to support entry to the workplace. OSCs could be housed in separate structures or situated in hospitals and even law courts (Keesbury & Thompson 2010, Keesbury et al 2012)

According to Berneth and Gahongayire (2013), an appropriate example of a well-structured, staffed and fully operational OSC is the Isange OSC in Kigali, established in association with the UN and the Rwandan government. Berneth and Gahongoyire (2013) stated that this OSC is situated in the Kacyiru Police Hospital (KPH), and is said to be operated by a single coordinator, three medical doctors, one gynaecologist, four GPs, one psychiatrist, nine psychologists, six social workers, one law enforcement officer and a medical forensic expert. It offers a free of charge 24-hour service for seven days a week and is equipped with STI prevention medication, HIV post-exposure prophylaxis, emergency contraception pills and other necessary drugs. Bernath and Gahongayire (2013) pointed out that each survivor who reaches the OSC is first attended to by a qualified social worker that offers necessary information with regard to all available services. The survivor is subsequently seen by different service providers each offering their speciality services. After the client has been interviewed and medically scrutinised, the client is treated according to her needs. For those clients that need a temporay place of safety they are accommodated in a safe house owned by the OSC and which comprises three beds and the necessities.

Various researchers such as Colombini et al (2012), Ellsberg et al (2012), Karki et al (2012), Lovett et al (2004), Madi and Sarsour (2012) and others have evaluated projects on OSCs. Grisurapong (2012) stated that only two of the studies were grounded on a non-randomised control design. These project assessments originated from a variety of nations and provinces, for example, Melanesia, Nepal, Occupied Territories of Palestinian, Indonesia, Thailand, Malaysia and Zambia. However, not one of the individual studies assessed the impact of OSCs on preventing or decreasing IPV.

However, there are indications that OSCs may improve the accessibility of women's support services as well as judicial systems. A non-randomised study of sexual abuse referral centres conducted in 2004 in the UK discovered that women in the other comparison regions revealed higher levels of unmet needs and accessed fewer services. Lovette et al (2004) indicated that the research findings in the comparison regions were restricted by the small number of study participants. However, evidence points to clients who access the services provided by the OSCs are extremely grateful for the kind of support they get and feel more enabled to regain their strength. Morel-Seytoux (2010) in an evaluation of one-stop centres in Zambia for children who have been sexually assaulted, found high levels of gratification amongst children survivors for the quality of services provided. A significant number of survivors observed the comprehensive and consultative manner in which employees performed their duties and also noted the empowering nature of the services provided. A UN Population Fund (UNFPA) case study conducted in 2009 found that survivors in 12 of the Puspita programmes in Indonesia which situated crisis centres for women in pesantren (Islamic boarding schools), shared their appreciation for the support offered by the pesantren authorities and, as a result, they were more prepared to divulge the issues of violence they had been subjected to (UNFPA 2009).

Other studies provide useful information on lessons learnt, in particular, that the functioning of OSCs is disadvantaged by the constraints of the organisations. Colombini et al (2012) and Chepuka (2011) stated that these constraints include the non-existence of capacity building activities, a scarcity of specialised staff, time constraints, a lack of funding, a lack of supervision, and the non-existence of a bidirectional referral system to other relevant services providers.

2.6.1.2.3 Use of shelters

Jewkes (2014) stated that the use of shelters has potential to lessen violence, especially when used for an extended period. Two studies embarked on in the USA in 1984 and 2004 found that most women (approximately 72% and 79%) stated that their use of shelters had been effective in reducing the abuse perpetrated against them (Sullivan 2012). Nevertheless, a very low percentage of women (approximately 6% and 10%) stated that the abuse perpetrated against them had worsened. Morrison et al (2007) cited a study by Sullivan and Bybee (1999) of women that were placed in a shelter and rendered advocacy services. The study found that those women who were enrolled in the treatment group underwent more abuse than those in

the control group over a short period of time but experienced less abuse after a longer period of time, that is, two years. A 1988 study in the USA by Bennet et al (2004) discovered a positive impact of shelters on women survivors who had already begun to modify their lifestyle prior to being admitted to the shelters. Sullivan (2012) mentioned three studies that asked women what they would have done if the shelter had not been available to them. Their rejoinders ranged from being homeless and experiencing continued violence to turning to prostitution to support themselves and their children. Researchers such as Tutty et al (1999) and Lyon et al (2008) found in their studies that survivors were even thinking of committing suicide or murdering the offender as a way-out option.

The use of shelters is also associated with women deciding to leave abusive relationships. A 2007 study revealed that for women suffering moderate to severe violence, the shelter was significantly related to ending the relationship (Panchanadeswaran & McCloskey 2007, cited in Sullivan 2012). A 1992 study found that the more services women used while in the shelter, the more likely they were to live autonomously post-shelter (Gondolf et al 1992, cited in Sullivan 2012). Numerous researchers have revealed that making use of shelters can assist survivors in developing hope, restoring what has been lost and making more wise and informed decisions about the safety strategies they can use once they opt to leave.

Criticism of research on shelters include the observation that those studies which compare women who use shelters with those who do not are compromised by other variables that affect shelter use, for instance, income level, education levels, access to other options, and the severity of abuse. It is also problematic to focus on the effect of shelters alone, as women are able to access a range of other services and interventions while within them. A further criticism is the fact that these studies rely on self-reported data from the shelter residents themselves. Therefore, there is no way of knowing what would have happened in their lives if they had not used the shelter. A noteworthy shortcoming of research among women in shelters is that it does not measure the return to the abusive partner after a period in the shelter.

2.6.1.3 Health sector responses

2.6.1.3.1 Healthcare professionals' training and screening interventions

Pande et al (2017) argued that the frontline (community) health workers are the most visible face of the healthcare delivery system in rural India. The authors further mentioned that the health workers are the most intimate contact that women in the community have with the government healthcare system. As the workers interrelate with the women on personal issues such as fertility and childbirth, this makes them the institutional actors best-placed to engage with women on issues as private as IPV.

There is limited evidence, of moderate quality, that preventive interventions or programmes undertaken in emergency departments (using PowerPoint presentations, videos and written material) may increase knowledge, change attitudes and improve practice, for instance, the willingness to intervene in a bystander situation. This evidence derives from two USA studies, neither of which considered behavioural changes as an outcome thus making the ultimate impact of these interventions on prevention hard to determine. Given the differences in context and the populations from which interviews were drawn, the findings of these studies may have limited generalisability to populations in other countries.

Jewkes (2014) pointed out that there is little evidence on interventions regarding the training of healthcare professionals aimed at building their knowledge and skills on IPV so that they can undertake screening. Screening is the process of identifying women who are experiencing or have recently experienced IPV when they attend health services. This includes the "routine" or "universal" screening that occurs when all women consulting a healthcare provider are asked about partner violence. Jewkes (2014) further stated that this is from "case-finding" or "clinical enquiry" which occurs when a woman is asked about violence based on her presenting condition and screening is usually accompanied by referral or some other intervention. The training usually includes how to ask women about violence, handling disclosure, documenting abuse, safety planning, developing specific guidelines and protocols for practice, and understanding locally available services for survivors should any referral be needed (Taket et al 2003). These training programmes are often provided in-service, with sessions lasting from an hour to several days. There have been efforts to incorporate training into undergraduate or basic training curricula for healthcare providers.

A significant number of research-studies have scrutinised the effect of screening initiatives on reducing violence against women including three large and well-conducted RCTs. Eight systematic reviews were found (Coulthard et al 2010; Feder et al 2009; Kataoka et al 2004;

Nelson et al 2012; O'Reilly et al 2010; Ramsay et al 2002; Taft et al 2013; Wathen & MacMillan 2003), six comprehensive reviews (Chepuka 2013; Evanson 2006; Garcia-Moreno 2002; Guedes 2004; Plichta 2007; WHO 2013), and six individual studies that were not included in the reviews. Most of the evidence is from programmes in the USA, UK, Canada, Australia and New Zealand. Nevertheless, there are a lesser number of mainly qualitative studies from Tanzania, South Africa and India. Insufficient studies differentiate between the screening approaches (routine or case-finding) being evaluated, and there are no studies comparing outcomes for women from universal screening and case-finding approaches (WHO 2013; Taft et al 2013).

It is critical to note that there is no evidence of the impact of training interventions on their own on IPV occurrences for women and this is rarely measured in evaluations of training. Likewise, there is no evidence of the effect on referrals to services and attitudes and beliefs. Moreover, there is also no evidence that screening leads to a reduction in violence or improves health outcomes for women. Numerous reviews conclude that the evidence does not justify universal screening (Taft et al 2013; MacMillan et al 2009; Feder et al 2009; WHO 2013). Taft et al's (2013) systematic review of 11 randomised or quasi-randomised trials found no evidence of increased referrals as a result of screening and insufficient evidence that screening increases the uptake of specialist services. The main finding emerging from almost all the reviews is that screening interventions undoubtedly escalate the identification of women experiencing IPV (Nelson et al 2012; Taft et al 2012; O'Reilly et al 2010; Plichta 2007; Guedes 2004). Taft et al (2013) found that screening is most effective in increasing the identification of women experiencing IPV in antenatal settings. However, this is only of value if combined with an intervention that is useful for women. Also, there is no direct evidence of the value of case-finding approaches but evaluating these in a RCT would be unethical or immoral as healthcare providers must ask about violence exposure if they perceive it to be relevant for the management of the presenting complaint.

2.6.1.3.2 Referral and case management

Screening interventions by healthcare professionals can be interconnected with referrals to care, follow-up and support services. These can include the offering of safety information, counselling, referrals to shelters and further healthcare. It is anticipated that such programmes

can go beyond improving the identification of women experiencing IPV to enhanced outcomes for women.

The WHO (2013) and Nelson et al (2012) provided two comprehensive reviews that dealt with programmes linking screening to various follow-up interventions. Researchers such as Jackson et al (2012), Tumbewaze et al (2009), Hegarty et al (2013) and Krasnoff et al (2000) provided strong evidence through well-conducted and documented RCTs in high-income settings, that large-scale interventions to screen and offer case management or referral are ineffective in reducing IPV. Six further RCTs, three of which were targeted at pregnant and post-partum women in the USA, UK, Canada and Australia, echoed the above findings. Cohort evaluation and qualitative studies from South Africa and Uganda were also included and both indicated the ineffectiveness of the referral and case management interventions.

The WHO (2013) review also included the findings of four large and well-conducted RCTs on post-screening action in healthcare settings. The most frequent actions were a prompt in the medical record of the screening test result given to healthcare providers before patient visits or automatic referrals to social workers or professional advocates. The review found that none of these studies demonstrated a decrease in the recurrence of IPV. Additionally, two studies have examined health outcomes and both found no transformations (Macmillan et al 2009, cited in WHO 2013). There is a possibility that providing interventions for pregnant women may be of more value but there is insufficient evidence. According to Nelson et al (2012), screening followed by counselling may decrease IPV and improve birth outcomes for pregnant women, decrease IPV for new mothers, and lessen pregnancy coercion and unsafe relationships for women in family-planning clinics.

In terms of the factors that affect the efficiency of programmes, effective case management requires that sufficient referral systems are in place, which can be also a challenge in resource-constrained contexts. A study conducted in the Kabarole District, western Uganda in 2009 to assess the management of GBV survivors in health facilities found that respondents experienced long waiting times at the health facilities they were referred to. Shortages of staff and the lack of privacy and medicines were also mentioned as common problems. Only a restricted range of healthcare services was offered to GBV survivors and these were generally at the request of the police (Tumbewaze et al 2009). Even in higher-income settings, there is evidence that most women who are or should be referred to services, do not show up.

2.6.1.4 Social sector responses

2.6.1.4.1 Counselling, therapy and psychosocial support

Therapy, counselling, and psychosocial support are similar types of mental health interventions and are usually used interchangeably. However, there are subtle differences:
(1) Counselling tends to refer to a relatively brief intervention that is focused on a particular symptom or problematic situation and offers support in dealing with it, normally through brief educational, cognitive-behavioural, and motivational interviewing approaches. (2) Therapeutic interventions are more concentrated treatments than counselling and focus on the patient's thought processes and way of being in the world, rather than specific problems. (3) Psychosocial support embraces the provision of practice assistance in the form of care and support to victims of violence and may, in addition, include counselling and therapeutic intervention. Treatment can last anywhere between one session to several years depending on the nature of the case and can be delivered to individuals, couples or groups. Interventions usually intend to promote improvements in mental health or wellbeing.

Numerous studies have investigated the effect of counselling, therapy and psychosocial support on violence against women. There are two systematic reviews (Wathen & MacMillan 2003; Tol et al 2013) and four comprehensive reviews (McCollum & Stith 2008; Keesbury & Askew 2010; WHO 2013; Spangaro et al 2013). Over and above these reviews, there are three further studies, namely, Hester and Westmarland (2005); Crespo (2010); and Spratt (2012). Most of the studies are from the USA and Western Europe, with a few from developing countries.

Numerous studies assessed combined interventions, making it difficult to disentangle the efficiency of one intervention versus another. For instance, a stay in a shelter followed by advocacy and counselling (Tol et al 2013; Wathen & MacMillan 2013).

There is no convincing evidence of the influence of counselling services on decreasing violence against women but some studies have found positive effects. An RCT study conducted in the Midwest of the USA that focused on women receiving counselling services following a stay in a shelter found that the intervention group reported significantly less violence than the control

group two years after the intervention (89% of women in the control group reported re-abuse vs 75% of women in the intervention group) (Sullivan & Bybee 1999, cited in Wathen & MacMillan 2003).

There is some evidence of a positive effect of counselling on communication in relationships as well as on the psychological health of women and children. For example, a mid-term evaluation of the Ending Domestic Violence Project conducted in Rwanda revealed that 44.4% of participants felt that counselling services aided them in improving dialogue in addressing issues that may lead to violence (Omollo-Odhiambo & Odhiambo 2011). Most evaluations concluded that there is a need for a more robust evidence base (Tol et al 2010; Keesbury & Askew 2010; and WHO 2013).

Numerous research-studies observing at the long-term impact of counselling or psychotherapeutic treatment for women victims of violence measured the impact on post-traumatic, depressive and anxiety symptoms, which is the immediate treatment goal (Crespo & Arinero 2010; Bass et al 2013; WHO 2013). However, no high-quality evidence exists which compares the effectiveness of different methods of treatment, attendance levels of individuals, duration of treatment, contextual factors, or how treatment outcomes vary by type of violence. Likewise, there is also a deficiency of high-quality studies viewing the impact of the counsellor or therapist's training, including the use of volunteers or lay counsellors. Even though a few studies mention the possible effects of individual, couple or group treatment, no study comparing outcomes between the different treatments was found. Couples treatment is extensively used in substance abuse programmes but it is considered controversial for the treatment of IPV. Nevertheless, McCollum and Stith's (2008) comprehensive review of the literature on "conjoint couples' treatment found that it can be safely utilised to treat IPV. Best practice in this regard comprises careful assessment and screening of couples for inclusion in couples' treatment; modification of typical couples' approaches to encourage safety; on-going assessment of safety with contingency plans for increased risk; and couples' treatment as part of a larger community response to IPV. A study of domestic violence counselling conducted in Rwanda revealed that a couples' approach was effective in preventing domestic violence as men felt part of the change process and played a key role" in reaching out to fellow men (Omollo-Odhiambo & Odhiambo 2011).

2.6.1.4.2 Advocacy and support to access services

Advocacy services intend to assist violated women directly by offering them information, knowledge and support to access resources in the community, especially legal redress. Several interventions also afford safety-planning advice and seek to empower women to achieve their goals (Ramsay et al 2009). Some advocacy programmes work on an extensive range of areas, while others focus on helping women access community resources and services such as housing, employment and legal or social support (Sullivan 2012). The engagement can last anywhere from 30 minutes to 80 hours depending on the nature of the case and its intensiveness. There is occasionally considerable overlap between advocacy interventions and counselling. The advocacy psychosocial support and counselling interventions are carried out by a range of individuals and organisations including social service professionals, students and trained lay mentors. This is done in a range of settings such as at home, by telephone, in community safe spaces and healthcare settings.

Numerous studies have investigated the effect of advocacy services on violence against women. Two systematic reviews (Ramsay et al 2009; Wathen & MacMillan 2003) and two comprehensive reviews (Sullivan 2012; WHO 2013) were identified. Four further studies that were not included in the reviews (Tan et al 1995; Sullivan et al 1999; Hester & Westmarland 2005 and Chang 2005) were also identified. Most of these studies have been conducted in the USA with one coming from Hong Kong. It is noted that the evidence concerning the impact is contradictory. There may be some notable reduction in physical IPV but not sexual and emotional, and it may be greater in the short term.

The most topical and comprehensive systematic review is Ramsay et al's (2009) review of RCTs comparing advocacy interventions for women with experience of intimate partner abuse against the usual care. Ten studies comprising a total of 1 527 participants were found to meet the inclusion criteria. The authors indicated that there was no compelling evidence that advocacy generally diminishes or leads to a cessation of abuse (Ramsay et al 2009: 46). Intensive advocacy (12 hours+ duration) may aid in reducing physical abuse in women leaving domestic violence shelters or refuges in the short to medium-term (one to two years follow up) but there is unreliable evidence on other forms of violence, such as emotional and sexual abuse. A longitudinal study which evaluated the effectiveness of three interventions, namely, briefing, counselling and outreach on 329 pregnant Hispanic women in the USA, revealed that extent of

advocacy significantly reduced the physical abuse experienced by the women. Arguably, the study design was weakened by the overlap between the three intervention types (McFarlane 2000). There is also some evidence confirming that brief advocacy increases the usage of safety behaviours by violated women.

The WHO (2013) review found that the most solid evidence on advocacy interventions arose from three advocacy trials conducted in Hong Kong (Tiwari et al 2010). The trials implemented advocacy or empowerment interventions of short-term duration with women in three settings: antenatal, shelter-based, and community health centre-based. The studies indicated benefits in violence outcomes in the two healthcare settings but there remains uncertainty about the intensity required for advocacy to have an impact (WHO 2013).

2.6.1.4.3 Perpetrators' (batterers) programmes

Perpetrators' programmes (also known as batterers' programmes) entail treatment or rehabilitation for perpetrators of domestic violence. These programmes can be mandated by a court order or perpetrators can choose to attend voluntarily. Naturally, the programmes or interventions involve the use of psycho-educational methods which aim to help men understand and acknowledge how their behaviour stems from patriarchal gender norms and beliefs about men's power and control over women, and aid them to obtain the skills to handle or control their anger without resorting to violence (Feder et al 2008; Babcock et al 2004). Such treatment can last anywhere between eight and 26 weeks and can be offered to individuals, couples or groups.

Many studies have investigated the effect of perpetrators' programmes on whether individuals return to IPV, that is, above and beyond what would have been expected to occur as a result of the arrest and associated legal procedures. Three systematic reviews (Smedslund et al 2011; Feder et al 2008; Wathen & MacMillan 2003) and three comprehensive reviews (Sartin et al 2006; Babcock et al 2004; Feder 2005) were identified. Two further individual studies – one quasi-experimental study and one cohort evaluation – that were not included in the reviews were also identified. The overwhelming majority of the evidence focuses on programmes implemented in the USA.

The most topical and comprehensive systematic review is the Smedslund et al (2011) study, which located six RCTs, all from the USA, and which comprised a total of 2 434 participants. The largest study had 861 interviewees. Four of the trials compared men who had received cognitive behavioural therapy (CBT) with those who had not. The two remaining studies compared men who were receiving CBT treatment with those receiving another form of treatment. Generally, there is a modest impact on reducing recidivism among those who attend, and are retained in, programmes of a longer duration. However, the findings are indecisive. A weakness of the findings is that most studies are dependent on criminal justice records to measure recidivism, whereas much violence is under-reported (Feder et al 2008). There is some evidence that men who complete treatment in these programmes were less inclined to replicate violence but most studies show there is a high dropout rate of at least 40% (Smedslund et al d2011). Two studies from the late 1980s of programmes ranging from eight to 15 weeks duration found that those who completed the treatment were less likely to recidivate than those who did not finish (Chen et al 1989; Hamberger & Hastings 1988). A follow-up evaluation that was conducted in 1997 of court-ordered treatment discovered that men who had completed treatment had significantly fewer re-assaults (both all assaults and assaults against women) than treatment dropouts, rejects and no shows (Dutton et al 1997).

Evidence on the value of treatments being court-controlled is contradictory. However, it seems that relatively longer duration programmes are more successful (compared to, for example, eight weeks or less). The 2003 case series of four programmes conducted over four years revealed that some programmes had accomplished a clear decrease in physical and psychological violence and that the vast majority of men were able to sustain non-violent behaviour (Gondolf 2003).

Other studies have resulted in important lessons about interventions. For example, some have confirmed that various treatment factors can affect the effectiveness of programmes in terms of their impact on recidivism. These include the length of the programme and individuals' attendance levels (Smedslund et al 2011), whether they are court-controlled (Davis et al 2000; Gondolf 2003), the levels of risk monitoring and the addition of other community members in the treatment groups (Brown & O'Leary 2000). Some studies have compared the effectiveness of different treatment methods but arrived at no conclusive findings. Other studies (for example, Johannson & Tutty 1998) found indications of an enhanced effect when both partners undertake prior gender-specific group treatment for domestic violence particularly in terms of

addressing psychological as well as physical abuse over the long-term. The studies that compared men who had completed almost all of their treatment programmes against those who had dropped out discovered that those who had dropped out were often older, more educated, sophisticated and more prone to be employed (Dutton et al 1997; Saunders 1996). It has been concluded that being younger and having a history of alcohol and substance abuse are associated with an increased likelihood of post-treatment recidivism (Murphy et al 1998; Shepard 1992). Several individual studies such as Gondolf and White (2001) and Dutton et al (1997) have discovered that psychological or personality traits such as psychopathic tendencies, borderline personalities, antisocial personalities and interpersonal dependency (Bowen et al 2005) are associated with recidivism.

2.6.1.4.4 Social marketing campaigns

Mbilinyi et al (2008) established a social marketing campaign intended to recruit male perpetrators of IPV to a telephone intervention programme. Other researchers struggled to establish images that would not at some stage "arouse defensiveness in men who were ambivalent about making changes" (Mbilinyi et al 2008:346). According to Mbilinyi et al (2008), there was an "Open Your Eyes" campaign established in 2006 that did not embrace similar care in compassionately addressing men. By contrast, this campaign employed a confrontational tone and employed gender-specific communications and images in its struggle to escalate consciousness of the ruthlessness of violence and the perceived response efficiency of IPV hotlines (Mbilinyi et al 2008). Mbilinyi et al (2008) stated that the Open Your Eyes campaign cascaded four television (TV) advertisements (ads), a billboard, and the three print ads. The TV ads were made to increase the perceived brutality of and vulnerability to IPV and perceived reaction efficiency of phoning IPV hotlines (Mbilinyi et al 2008). It was made certain that each of the ads was followed by facts on the occurrence of domestic violence, with a prompt to use a telephone hotline for domestic violence services. According to Keller et al (2010), the quantitative evaluation of the campaign found critical differences in the responses of women and men: women's insight in terms of ruthlessness, consciousness of services and perceived reaction efficiency improved after the campaign whilst perceived brutality dramatically declined for men (Keller et al 2010).

Subsequently, social marketing campaigns appear to be more effective when compared to other types of interventions as they have evidence of being effective. Campaigns underlying

"voluntary" attitude and behaviour change related to men's commission of violence seem to be effective. Campaigns which incorporate social media (for example, Facebook, Twitter and YouTube) appear to gather more attention on the issue.

Notwithstanding the efforts to prevent IPV by both government and non-government organisations (NGOs), IPV rates are unceasingly increasing. Evidence illustrating this was cases of domestic violence in the UK increasing by 35% between 2010 and 2011 (Daily Mail Online 2011). Women alone were the victims of over 70% of the occurrences of domestic violence (British Crime Survey 2009/2010 2011). At least one in four women in the UK will experience domestic abuse in their lifetime and 73% of occurrences of domestic violence were experienced by recurrence victims (Flatley et al 2011). In the USA, the National Crime Victimization Survey (2008) statistics indicated a 42% upsurge in reported domestic violence and massive increases in the frequencies of domestic violence, rape and sexual assault over two years. The ever-present issue of domestic violence escalated in Australia (VicHealth 2009); for instance, the Victoria regent reported a 26% increase in the number of violations related to family violence (Akerman 2011). The above demonstrates escalating trends in all the major countries where domestic violence is prevalent despite innumerable measures having been undertaken to curb the escalation. Consequently, other intervention and prevention strategies should be employed to curtail the issue of domestic violence generally and IPV specifically. Furthermore, this suggests that social marketing approaches can help in identifying opportunities for agencies with regard to both perpetrators as well as victims of IPV.

2.6.2 Intervention programmes dealing with intimate partner violence: Africa and sub-Saharan Africa

Most IPV preventive programmes have not been thoroughly evaluated. The few that have been evaluated were primarily undertaken in developed countries. Hence, there are very few comparable, contextually related programmes to benchmark against (Heise 2011; Nation et al 2003; McHugh & Frieze 2006; Lawoko 2006). It is noted that IPV is affecting women globally and especially women in sub-Saharan Africa. There is a necessity for interventions that address IPV in all settings. Huge multi-layered community-based intervention programmes showed promise in the areas of addressing social norms to empower women.

Thus far, two large RCTs have been conducted in sub-Saharan Africa, specifically in South Africa, to assess multi-layered intervention strategies addressing the prevention of IPV. The Intervention with Microfinance for AIDS and Gender Equality (IMAGE) study assessed an HIV and gender equality educational intervention in addition to a microfinance programme for adult women (Jan et al 2010; Jan, Pronyk & Kim 2008; Kim et al 2009; Kim et al 2007; Pronyk et al 2006; Pronyk et al 2008). Jewkes et al (2008) reported on the Stepping Stones intervention which consisted of approximately 50 hours of participatory education presented to both men and women and provided over a six-to-eight-week period. It included content concerning sexual health and risk behaviours, contraception, HIV, communication skills and GBV. This was initially developed for Uganda and has subsequently been adapted for use in more than 40 countries and 13 languages (Jewkes, Wood & Duvury 2010).

Both the Stepping Stones and the IMAGE interventions displayed promise in decreasing IPV. The IMAGE study reported that IPV rates were 49% lower in the group that received the gender-based education component in addition to the microfinance component. Furthermore, fewer men partaking in the Stepping Stones intervention programme reported IPV perpetration at 24 months when compared to those in the control group. The two intervention programmes offered some direct services such as microfinance programmes and crisis hotlines in addition to the education component (Fawole et al 2004; Jansen van Rensburg 2007).

A succession of intervention programmes to address GBV against young high-risk women in Nigeria commenced with reproductive and HIV education, added behavioural risk reduction programmes utilising peer educators, and escalated to linked referrals to STI and family planning services along with a microfinance programme (Fawole et al 2004). As the interventions intensified, target populations were extended to include several groups of at-risk women as well as secondary targets that included police officers and older women and men who had received a single education session addressing HIV and GBV topics (Fawole et al 2003). The one-year assessment presented an increase in reported GBV knowledge and a decrease in reported rape attempts from 26% to 2% and stranger rape from 6% to less than 1%.

2.6.3 Intervention programmes dealing with intimate partner violence in Southeast Asian countries

There is limited research existing on the effectiveness of IPV programmes in Southeast Asian countries. Solotaroff and Pande (2014) studied the characteristics and outcomes of intervention programmes in these countries and stated that most of the programmes in this region were provided by NGOs and mainly funded by international donors such as Oxfam, the UN Development Program (UNDP) and the Asia Foundation. What has been noted is that the IPV programmes are done at the primary and secondary level. The main emphasis of primary interventions is the prevention of violence by addressing underlying attitudes and cultural norms. These programmes are employed on a large scale through awareness-raising campaigns that employ mass communication, that is, social media, radio, television and print media. A recognised evaluation of the prevention programmes has not been identified. Nonetheless, the essentially positive response toward these programmes suggests that they are efficacious in terms of gaining the attention of the masses, both men and women, and in challenging the general acceptance of violence at the societal level.

2.6.3.1 Grassroots awareness campaigns

Awareness campaigns are also ways of reducing violence. The Bell Bajao campaign, established in 2008, was considered very effective in promoting awareness about IPV in India (Lapsansky & Chatterjee 2013). This campaign is said to have used existing community networks and implemented innovative ways to deliver information. A combination of activism, mass media, and community involvement played a critical role in attaining significant positive outcomes (Breakthrough 2016). The Suriya Development Organization in Sri Lanka ran a campaign, "Clothesline", to raise awareness about IPV. In the beginning, it was perceived negatively but was later found to be efficacious in raising awareness, resulting in more talk amongst the masses on how to address the challenge of IPV. A campaign led by Oxfam called "We Can" was launched in India, Pakistan, Bangladesh, Nepal, Afghanistan and Sri Lanka (Rakib & Razan 2013). It was also found to create a greater public awareness of IPV (Rakib & Razan, as cited in Solotaroff & Pande 2014). Another campaign which was employed on a huge scale in India and found to be very successful was "The Men's Action to Stop Violence against Women" (MASVAW).

Two of the most universally funded approaches to address violence in underdeveloped and developing nations are awareness and advocacy campaigns (Heise 2011). However, many previous interventions have been ad hoc, short-term and small in scale (Horn 2012) habitually

taking the form of standalone awareness campaigns. Whereas such campaigns can create a platform for local advocacy initiatives, they are less effective at shifting behaviours. Heise (2011) argued that there is evidence that with campaigns like the "We Can" campaign described above, syndicate communication strategies with a community mobilisation approach, hold promise.

IPV awareness campaigns are expensive and strengthen arguments for the intervention of government, social institutions and businesses. However, they do provide a reference point to inform service providers on necessary IPV interventions as most IPV cases would emerge during or after these awareness campaigns. Since these expenses affect everyone, even though the violence may be private, the campaigns bring IPV into the open as a societal issue.

2.6.3.2 Community focused interventions

The key focus area to date in VAWG programming has been on engaging individuals to re-examine their attitudes and on awareness-raising activities, rather than engaging whole communities around social norm change. Community mobilisation is a promising method which pursues to inspire deviations in social norms and behaviour through community activism. It rests on the idea that effective violence prevention depends on community members leading efforts in their community and is encapsulated in the expression "Nothing about us without us". The intention is to build a critical mass of individuals and groups who no longer tolerate VAWG. Remme et al (2015) argued that approaches to transforming norms at the community level include a community mobilisation intervention aimed at transforming norms relating to violence and HIV. A community mobilised intervention found to be effective in combating violence is SASA! in Kampala, Uganda. SASA! is aimed at preventing VAWG through altering "community attitudes, norms and behaviours that underlie power imbalances between men and women and support both HIV risk behaviours and the perpetuation of violence against women" (Abramsky et al 2012:4) This intervention is intended to take communities through four stages of change beginning with identifying linkages between violence and HIV risk, followed by raising awareness, supporting men and women affected by violence to change and, finally, taking action to prevent violence. These intervention activities are championed by community activists, community and institutional leaders, healthcare workers and police, all of whom are supported and mentored by SASA! staff and provided with bi-monthly training opportunities.

2.6.3.3 Training and capacity building

Jewkes (2014) stated that there is no study assessed the effect of capacity building activities and training in decreasing incidences of VAWG and this was usually because the impact assessments were not a defined objective of the interventions. Nevertheless, there is some evidence that training programmes may be able to bring about changes in attitudes and behaviours of police and security personnel, and may have improved credibility amongst survivors (Khalique et al 2010; UNFPA 2008).

According to Jewkes (2014), obligatory arrest procedures have been shown to escalate arrests in the USA, as well as cases brought into the criminal justice system (and to the attention of prosecutors) and, consequently, these policies can disrupt the occurrence of violence in the short term. However, prosecutors have often found that survivors, who are pressured to bring cases, are reluctant to testify (Epstein 2003, cited in Goodmark 2007). They are hesitant to use the legal system against their partners, mistrust the judicial system, and are fearful that perpetrators may become more violent as a consequence. There is evidence that some perpetrators may become more violent after arrest or prosecution, particularly those who were unmarried and unemployed (Sherman et al 1992; Pate & Hamilton 1992). Two reviews of mandatory arrest policies in the USA revealed that they can have inadvertent negative consequences for women and girls especially if they are also arrested for committing violent acts in self-defence (Chesney-Lind 2002; Goodmark 2007).

Gielen (2000), Rodriguez (2001) and the WHO (2013) argued that no studies have been found that measure the effects of mandatory reporting by healthcare workers or other professionals on the occurrence of VAWG, particularly IPV. Some studies have found that fears of undesirable consequences stemming from a mandatory reporting policy may discourage women from revealing domestic violence to healthcare providers (Gielen 2000; Rodriguez 2001; WHO 2013). There are conflicting research findings as to whether a majority of violated women support mandatory reporting. Rodriguez et al (2001) found that a majority of women were in favour of such reporting. However, several studies have shown that violated women have a fear of being at greater risk of violence following a mandatory report (Malecha et al 2000). The WHO review (2013) suggested that mandatory reporting should not be undertaken as it undermines women's autonomy and decision-making and may place them at risk.

Jewkes (2014) stated that there is conflicting evidence on whether second responder programmes lead to increased violence. Davis et al (2008) argued that these programmes slightly improve the inclination of survivors to report incidents to the police, possibly as a result of greater confidence in the police. However, two studies from second responder programmes employed in the USA found that the treatment groups were more likely to experience violence than the control group (Davis et al 2008; Hovell et al 2006). Comparative research involving women receiving second responder services in New Zealand revealed that treatment group women had more optimistic views about their interaction with police officials than control subjects did (Fisher 2004).

Another category of interventions found to be effective is group-based gender equity education and collectivisation/empowerment activities that are delivered alongside or on top of large-scale social services. These include, for example, the Microfinance for AIDS & Gender Equity (IMAGE) intervention. The IMAGE trial in South Africa pooled a poverty-focused microfinance initiative with a gender and HIV training curriculum called Sister for Life. Remme et al (2015) have in high regard various well-known primary prevention community-based interventions such as Somos Diferentes and Somos Iguales in Nicaragua, IMAGE in South Africa, SHARE and SASA! in Uganda, Program H in India, and Stepping Stones in several countries around the world. These interventions all share fundamental principles that allow them to be efficacious in reducing the prevalence of IPV.

2.6.3.4 Community support networks

In many contexts, particularly in remote communities, few resource service centres exist to meet the immediate medical and psychosocial needs of survivors of violence (Irish Joint Consortium on Gender-based Violence 2010). Even in communities where services exist, the sad reality is that most survivors of violence never use them (Heise 2011). The WHO's multi-country study on domestic violence found that those who do seek support turn to informal networks such as the immediate family or close friends as opposed to seeking help from formal services (Berik 2017). Strengthening informal support networks and linkages, including equipping those around women in the community to respond appropriately to disclosures of violence, is consequently critical in terms of meeting the needs of women survivors of violence at the community level, particularly in remote areas.

2.6.3.6 Using media and technology

According to Smithey and Straus (2004), public attention on the mass media has mainly focused on the degree to which the media has granted models and incentives for violence, including IPV. Smithey and Straus (2004) argued that films, TV, videotapes and electronic games have a massive violence component. It was learnt that minimising access to such can reduce violent behaviour (Robinson 2001). Anderson and Bushman (2001) indicated that a meta-analytic review of studies on exposure to violent video games established that they increase violent conduct, views, and emotions as well as reduce pro-social conduct. Nowadays technological advances, like v-chips in TVs, permit caregivers to prohibit violent programming.

Even though the media is widely perceived as violence-promoting, it is well-positioned to make a massive contribution to IPV primary prevention. This can include public service ads and programmes aimed at raising awareness of IPV and informing the public on types of interventions or programmes available for IPV. Heise et al (1999) indicated that in Iztacalco, México, a massive media public awareness campaign was implemented to force a change in legislation and raise public consciousness of wife abuse. An even more influential prevention outcome could occur through topics such as IPV being presented in the media as a result of writers as well as directors' efforts to tap into current public concerns.

The media, as a "culture creator", can be an influential ally in shifting public opinion on VAWG. A range of media approaches has proven effective in cascading information, rallying support and instigating dialogue which can challenge gender norms around VAWG. These approaches range from the mass media to less conventional community and participatory media approaches. For instance, there is a growing popular entertainment or "edutainment" industry which is having some success in mobilising communities towards social change through television and radio (Reeves & Esplen, cited in Cusack & Pusey 2012).

More evidence is needed on media and technology's effectiveness in interventions with more diverse populations experiencing violence as well as interventions tailored to women from specific groups, such as those with disabilities and/or from ethnic minorities. Furthermore,

there is still a lack of evidence on interventions to address "honour-based" violence against women or forced marriage.

2.6.4 Intervention programmes employed by South Africa in dealing with gender-based violence

2.6.4.1 National policy and legislative framework on violence against women

South African laws on women's rights have been developed in line with international laws and regional jurisprudence. They have been translated into provisions in the national Constitution that recognise the right to life, human dignity, freedom and security, liberty from all forms of violence from public or private sources, as well as bodily and psychological integrity. More specifically, a provision on equality states that "…the state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth."

IPV in South Africa has been a long-standing issue of concern for the post-apartheid state, as evidenced in the National Crime Prevention Strategy's prioritisation of VAWC as a national issue through the fundamental areas of intervention such as prevention, protection, prosecution and victim empowerment. Other legislative provisions and interventions towards contesting IPV have been advanced over the years including the Domestic Violence Act (DVA 1998) which replaced the Prevention of Family Violence Act (PFVA 1993); the Promotion of Equality and Prevention of Unfair Discrimination Act (2000); the Criminal Law (Sexual Offences and Related Matters) Amendment Act (SOA 2007) together with preceding forms; the Protection from Harassment Act (2011); the Employment Equity Amendment Act (2013); and the Prevention and Combating of Trafficking in Persons Act (2013). The existence of several policy frameworks informed by these laws, including the Strategy for Shelters for Victims of Domestic Violence in South Africa 2003, also emphasise the recognition of, and attempts to deal with, IPV in South Africa. The above laws are a recognition of state accountability, as they were introduced and endorsed by the state in collaboration with other actors, including the women's movement in South Africa. These laws have engendered policy directions backed by the specific architecture of the institutional environment.

2.6.4.2 Domestic Violence Act (1998)

South Africa is known to have the unwanted reputation of being one of the most violent countries in the world. Most pertinent for this research is IPV. Vetten (2005) argued that the Domestic Violence Act (DVA) originated through the efforts of the women's movement and the networking of women politicians and bureaucrats. This occurred in the favourable environment of democracy and a unified gender framework in the wake of South Africa's transition from apartheid to democracy. Promulgated to deal with domestic violence in South Africa, the law substituted the initial legislative attempt to intervene in domestic violence, the PFVA (1993). Improvements are seen in its broad definition of domestic violence and the overview of statutory internal and independent oversight of police enforcement of the law. The DVA intends to afford the victims or survivors of domestic violence the maximum protection from domestic violence that the law can provide. The act also presents measures which seek to ensure that the pertinent organs of state give full effect to its provisions thereby conveying that the state is committed to the eradication of domestic violence (Preamble to the Domestic Violence Act No. 116 of 1998).

The DVA was put into place to facilitate the serving of protection orders on perpetrators and requires that police officers take victims or survivors to a place of safety (Hassim 2004). The act allows police to seize firearms at the scene and to arrest perpetrators without a warrant. Violation of a protection order is punishable with a prison sentence of up to five years or 20 years if additional criminal charges are brought. According to statistics from the South African Police Service (SAPS), the national ratio for rape is at 118.3 per 100 000 inhabitants. The uppermost ratio is found in the Northern Cape at 173.3. In 2006/7 a total of 52 617 rapes were reported to the police. However, innumerable sources are confident that the actual number of rapes is at least twice to nine times as high.

While it is true that the government has done remarkably well in terms of its efforts to adopt a multi-faceted and integrated approach to raising awareness and improving service delivery to fight violence against women (VAW), it also faces extensive challenges in implementing these efforts. The impact of the DVA towards the victims of abuse has been restricted due to a lack of coordination, support systems for victims, resources at courts and police stations, and the presence of pervasive patriarchal values. The Department of Justice and Constitutional

Development has also not been able to develop an adequate approach to assessing court performance concerning GBV. A South African study found that protection orders were only finalised in about half of cases where temporary protection orders and been granted (Mathews & Abrahams 2001). Even though men could be arrested for violations of protection orders, they were speedily released and many women feared for their safety. Some women reported that the effect of protection orders was short-lived and others revealed a shift to emotional abuse. It is believed that protection orders are hard to implement in low and middle-income settings where possibilities for autonomous residence are limited due to economic and socio-cultural constraints.

2.6.4.3 Promotion of Equality and Prevention of Unfair Discrimination Act (2000)

The Promotion of Equality and Prevention of Unfair Discrimination Act 4 (2000) strives to avoid and prohibit unfair discrimination and provides for redress for discrimination. According to Pieterse (2000), the act has resulted in much discussion on the future of customary law that is rooted in values of patriarchy, as well as on the issue of human rights. It has been debated (Pieterse 2000) that the abolition of customary practices that discriminate largely against women is not merely obligated by the right to fairness, equality and the right not to be discriminated against in Section 9 of the Constitution but also by international human rights, specifically by the UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) that South Africa has signed and ratified. In contrast, legislation such as the right to culture (Section 31 of the Constitution) commands a degree of lenience or acceptance for customary law which makes it harder to successfully combat issues of IPV in some communities.

2.6.4.4 Criminal Law (Sexual Offences and Related Matters) Amendment Act (SOA 2007)

The Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 (2007) is aimed at clamping down on the sexual abuse of women and children by adults and contains measures outlawing trafficking for purposes of sexual exploitation. According to Pithey and Smythe (2011), the Sexual Offences Act (SOA) brings together, organises and reviews South Africa's laws dealing with sexual offences. Pithey and Smythe (2011) state that the amended act, in addition to qualifying sexual offences in line with the South African Constitution, has also

included new offences such as child pornography. A crucial contribution in contesting IPV has been the act's redefinition of rape, which is defined as intentionally committing an act of sexual penetration without consent, irrespective of gender (Sibanda-Moyo et al 2017). The new definition of rape acknowledges the diversity of women in that rape can be committed against not only heterosexual women, but also against other women and transgendered people, whether straight, lesbian, gay, bisexual or asexual (Sibanda-Moyo et al 2017). The act captures sexual offences against children and persons with disabilities, together with sexual exploitation. It also authorises courts to offer specialised victim-support services to militate against secondary victimisation or traumatisation, reduce case handling time and increase conviction rates. The services are carried out through the Sexual Offences Courts which were re-established in 2013 by the Department of Justice and Correctional Services. The courts have skilled officials that are well trained and equipped, private waiting rooms for witnesses, and rooms for survivors to testify. Efforts are being made to get supplementary regulations that will advance the competence of these courts including being sensitive and empathetic to persons with disabilities (HRC 2005) These courts have been categorised as a "game-changer" as the significant rise in conviction rates for sexual offences has been attributed to their formation. Pithey and Smythe (2011) stated that the SOA works in conjunction with the South African Police Services' (SAPS) National Instructions on Sexual Offences, and the National Directives and Instructions on Conducting a Forensic Examination on Survivors of Sexual Offences.

2.6.4.5 365 Day National Action Plan to End Gender Violence

In response to the call by the UN, and as an extended version of the International 16 Days of Activism for No Violence against Women and Children (VAWC) (25 November-10 December) awareness campaign, the government of South Africa runs an annual campaign to fight VAWC including IPV (Van Baaren 2018). Although South Africa implemented the 16 Days of Activism campaign in 1998, the government and multiple partners adopted the 365 Day National Action Plan to End Gender Violence in what is known as the Kopanong Declaration in 2006. The action plan, which is multisectoral and encompasses several stakeholders, is also in agreement with the uppermost priority of the declaration, that is, to strengthen and place far greater emphasis on prevention (Sibanda-Moyo et al 2017). The plan is comprehensive and addresses the necessity for a stronger resolve and a practical approach to end VAWC including IPV in South Africa. Well-recognised efforts put into this led, in 2007, to a finalised framework of operation – the 365 Day National Action Plan to End Gender

Violence. The plan outlines particular programme interventions complemented by tasks to be performed by particular stakeholders as well as the targets, indicators and timeframes to enhance the monitoring of impacts (Mataba 2016). The interventions are conducted through 10 thematic areas of legislation and policy; the criminal justice system; specialised facilities; comprehensive treatment and care; infrastructure and places of safety; public education and awareness; media communications; economic empowerment; children; and coordination (Maluleke 2012). The plan also highlights gender relations in problematising VAWC, thus focusing on men and boys as partners in combating this violence.

Furthermore, the Commission for Gender Equality (CGE) has the responsibility of monitoring the implementation of the plan and moving towards all the other obligations made in the Kopanong Declaration. Given its comprehensive and inclusive nature (which is in line with international best practice in the fight against VAWC, South Africa's 365 Day National Action Plan to End Gender Violence has received several optimistic reviews (Maluleke 2012). Nduna and Nene (2014) stated that a 2014 evaluation of its implementation in terms of its five targeted pillars (prevention, response, support, advocacy and awareness-raising, and coordination and communication) as well as one conducted by the CGE in 2012, suggest that improvement has been made in accomplishing the objectives of the plan. However, weaknesses in the form of its focus on men and boys as partners, issues of funding and a lack of cooperation among stakeholders have been identified as plaguing its implementation (Sibanda-Moyo et al 2017). Regardless of the following statement attributed to one of the reviews, the determination of combatting VAWC cannot be ignored: The evaluations of the 365 Days National Action Plan to End Gender Violence pillars strongly emphasise that GBV has mainly been addressed and construed through reacting to the aftermath of such violence (Colvin 2013). In light of the challenges mentioned concerning the 365 Days NAP, the recommendations call on the state to assume robust leadership in ensuring gender equality and to fast-track the action programme with clear indicators and baseline data to facilitate monitoring. The existing governance needs to have sufficient authority and finance to be able to embrace all layers of government accountable, to build capacity and to coordinate. The good working relations between the various role-players of the National Gender Machinery (NGM) and civil society need to be institutionalised for the NAP to be effective. Finally, local organisations like NGOs and community-based organisations (CBOs) need to be capacitated through training and support.

2.6.4.6 Victim Empowerment Programme

In response to South Africa's high rates of violent crime in general and the unproductive focus of previous strategies on retributive justice, a new national crime prevention strategy inaugurated in 1998 focused on restorative justice, a victim-centred approach to criminal justice. In addition to the punishment of perpetrators of violent crimes, the strategy enables survivors to recover from their traumatic experiences. Consequently, a national Victim Empowerment Programme (VEP) was eventually rolled out as a criminal justice programme to support survivors of violence, as well as their families, in coping with the impact of the experience of violence. Primarily, the VEP is aimed at developing a victim-friendly criminal justice system, offering quality services to survivors and promoting intersectoral and departmental collaboration in victim-centred interventions. The existing version of the VEP is viewed as an enhancement on earlier versions. However, it is still perceived as lacking the legislative clout of enforceability and answerability (Dlamini 2015).

The VEP is channelled by policy and guidelines that define who a victim is based on the Victims' Charter, and the kinds of support, services and principles that constitute victim empowerment (Department of Social Development 2007). The programme functions as an intersectoral collaboration headed by the Department of Social Development (DSD). Collaborating departments include the South African Correctional Services, Justice and Constitutional Development, Police Services, National Prosecuting Authority and the Department of Health. It is important to note that NGOs and CBOs are also incorporated. These different role players have diverse responsibilities in the provision of services, varying from assisting in the registration and investigation of a case by first respondents, to offering medical, legal and health services by professionals and, eventually, prosecuting the case through the courts. Hence, the collective character of the VEP is principled on strengthening easier access for survivors to a continuum of services of care from the different departments, organisations and agencies that play different roles in providing support and services to survivors of crime and violence. The model of collaboration has, however, being questioned in terms of being able to achieve the aims of the VEP. In this regard, an implementer of the VEP has advocated for a modification in the framing of the collaboration as it does not have the ability to get a momentous level of engagement from other departments (Thorpe et al 2011). As a national programme, the South African government has set up forums at national and provincial levels

where the different departments involved can together strategise, monitor and evaluate the delivery of services to victims regularly.

The long-standing issues of untrained frontline responders and a lack of funding for NGOs and CBOs operating at the local level have also been raised as challenges to the implementation of the VEP (Sibanda-Moyo et al 2017). In terms of IPV against women, the VEP is also guided by the provisions made in the DVA (1998) including the obligations of the police and the criminal justice system as well as those in the SOA (2007). However, the criticism has been that whilst the laws oblige specific actions from the police, except for policy guidelines, there are no corresponding legal obligations on the part of other departments (Dey et al 2009)). Dey et al (2009) have argued that since 2009 determinations have been made for the VEP to be legislated. In doing so, the obligations of the different role players could be made legally binding and a new model of cooperation for the VEP recommended. Nonetheless, the potential of the VEP to offer relief is heavily influenced by operational concerns, the adherence of the different role players to its principles as well as the need for close and regular monitoring.

2.6.4.7 Protection from Harassment Act (2011)

Goh and Yip (2014) describe harassment as directly or indirectly engaging in conduct that the respondent (in a harassment case) knows or ought to know is causing harm or inspires the reasonable belief that harm may be caused to the complainant or a related person. Harassment entails but is not limited to: "(i) following, watching, pursuing or accosting of the complainant or a related person, or loitering outside of or near the building or place where the complainant or a related person resides, works, carries on business, studies or happens to be; (ii) engaging in verbal, electronic or any other communication aimed at the complainant or a related person, by any means, whether or not conversation ensues; or (iii) sending, delivering or causing the delivery of letters, telegrams, packages, facsimiles, electronic mail or other objects to the complainant or a related person or leaving them where they will be found by, given to, or brought to the attention of, the complainant or a related person" (Landman & Ndou 2013:82).

Goh and Yip (2014:82) further defines sexual harassment as any: "(i) unwelcome sexual attention from a person who knows or ought reasonably to know that such attention is unwelcome; (ii) unwelcome explicit or implicit behaviour, suggestions, messages or remarks of a sexual nature that have the effect of offending, intimidating or humiliating the complainant

or a related person in circumstances, which a reasonable person having regard to all the circumstances would have anticipated that the complainant or related person would be offended, humiliated or intimidated; (iii) implied or expressed promise of reward for complying with a sexually-oriented request; or (iv) implied or expressed threat of reprisal or actual reprisal for refusal to comply with a sexually-oriented request".

The Act intends to offer a remedy in the form of protection which would forbid a person from harassing another person. If the harasser breaches a protection order he or she commits an offence which is punishable with a fine or a period of imprisonment.

2.6.4.8 Employment Equity Amendment Act (2013)

Liliane and Mbabazi (2015) pointed to the Swedish International Development Cooperation Agency (Sida) which suggested that preventing and responding to GBV should include efforts to increase women's economic empowerment that would enhance their bargaining authority and ability to leave abusive relationships. These efforts include strengthening women's entrepreneurship and employment opportunities, improving their access to land and property rights, endorsing equal sharing of unpaid care work between women and men, and inspiring universal access to quality education. Liliane and Mbabazi (2015) further suggested that while such efforts can contribute to increased IPV against women in the short term due to gender stereotypes linking masculinity to the provider role, improving women's economic empowerment is still crucial for the long-term prevention of IPV. Women's economic empowerment programmes which also address gender norms and reach couples and communities can lessen the vulnerability of women to IPV**.**

As a way of promoting women economic empowerment, South African corporations employing 50 or more employees or those with a quantified financial turnover above a specified amount are mandated to comply with the provisions of the Employment Equity Act. Before the introduction of the act, large corporations had already introduced affirmative action to achieve employment equity. With regard to the act, the first democratic South Africa President, Mr Nelson Mandela, stated that "…the first point to be made is that affirmative action must be rooted in the principle of justice and equality" (Human 1993:3) and this included the inclusion of women.

To encourage equality of opportunity and treatment in access to employment and specific occupations, a member shall make certain that private employment agencies treat workers without discrimination based on sex, race, colour, religion, political opinion, national extraction, social origin, or any other form of discrimination covered by national law and practice (Burger & Jafta 2010). The Employment Equity Act forbids all 'persons' from unfairly discriminating against employees (Burger & Jafta 2010).

2.6.4.9 Government department initiatives

Numerous researchers including Watts et al (2007), Dunbar et al (2008) and Parkes (2015) believe that the threat of poverty sometimes forces women to tolerate violence as they are financially dependent on their partners. The Sida (2015) report, citing an in-depth study on all forms of violence against women conducted by the UN (2006), reveals that violence prevents women from contributing to, and benefiting from, development by restricting their choices and limiting their ability to act. The resulting consequences for economic growth and poverty reduction should be of central concern to governments. It is critical to note that eradicating poverty thus requires a sustained focus on tackling GBV. Between 2004 and 2009 the Extended Public Works Programme (EPWP) had a target of creating one million jobs, at least 40% of which should benefit women. This target was surpassed in June 2006 across its four intervention sectors with 52% of the EPWP beneficiaries being women. Furthermore, KZN, as one of the vulnerable provinces where a majority of vulnerable rural women reside, had the highest percentage (62%) of female beneficiaries in the country.

The African Peer Review Mechanism (APRM) (2007) cites the Working for Water (WfW) programme which was established in 1995 by the Department of Water Affairs and Forestry. It aimed at creating job opportunities for women through clearing invasive alien plants which impact negatively on indigenous biodiversity and local livelihoods. The programme targeted a workforce comprising 60% women and by 2005/6 52% of those employed were women from the most marginalised sectors of society. Furthermore, the Working on Fire Programme which focuses on fire management was implemented in 2004 and has reached a participation rate of 26% women, up from almost zero.

The South African government, through the DSD, provides an avenue for CSOs and CBOs to combat violence against women including IPV. These linkages include the area of funding.

The South African government finances shelters for victims of GBV with the DSD as the lead department responsible for coordination and facilitation of the placement processes. These shelters provide a range of services for the victims such as residential facilities, food and clothing, protection, and counselling and skills development services such as building the capacity and skills of victims and raising their awareness about victim rights. The initial 86 shelters in 2005 were concentrated in urban areas thus discriminating against provinces with significant rural populations. North West Province, for example, only had two shelters while Gauteng and the Western Cape had 24 and 19 shelters respectively. It can be claimed that this imbalance is due to the more urbanised provinces having a larger concentration of population and subsequently more GBV incidences. Nevertheless, the necessity for such services is more urgent in remote areas given the lack of awareness and the absence of alternative services in these areas.

The DSD is not the only department that is mandated to combat issues of GBV in South Africa. The South African Police Service (SAPS) has also made a significant impact in fighting the scourge of GBV having converted 66 Child Protection Units to Family Violence, Child Protection and Sexual Offences Units (FCSs) (Kamali 2015). According to Reyneke and Kruger (2006), the government operates 62 sexual offences courts throughout the country which offer designated waiting rooms and counselling for victims which are said to be victim-friendly.

Over and above the work done by the SAPS, The Department of Justice and Constitutional Development, through its Directorate, the National Prosecuting Authority's (NPA) Sexual Offences and Community Affairs Unit (SOCA), operates the Thuthuzela ("Comfort") Care Centers (TCC), which are specialised in rape care management. The focal objective of the TCCs is to offer support to victims of rape in a holistic manner irrespective of age and gender. Existing investigative, prosecutorial, medical and psychological services are coordinated and located in one building, hence some called them one-stop centres. The TCCs cooperate with women NGOs specialised in IPV or domestic violence and child abuse to offer an even more inclusive centralised service. The model has been documented as a "best practice" by the UN and been replicated in Chile. However, it is noted that TCCs are all in urban areas thus discriminating against the remote rural areas where services are most needed but generally lacking.

2.6.4.10 Thuthuzela Care Centres (TCCs)

In the spirit of the VEP and in consensus with the SOA (2007), TCCs were established under the leadership of the National Prosecuting Authority's Sexual Offences and Community Affairs Unit as one-stop facilities to afford services to survivors of sexual offences. They function from public hospitals and are strongly linked with the sexual offences courts. As an indispensable part of an anti-rape strategy, they empower rape survivors to lodge a case with the police and receive counselling and medical care in one place to avoid secondary victimisation. Even though praised as a best practice for the delivery of services under one roof to survivors of sexual offences, their numbers are recorded as insufficient, and lack of funding from the state is always a matter of concern. Given their recorded efficiency in decreasing secondary victimisation and trauma as well as their professional forensics which has improved conviction rates, their non-existence in rural areas and the limited number of trained officials are challenges. It has also been observed that the quality of the psychosocial care services provided is uneven across different centres (HRC 2005). Other similar models are Khuseleka (one-stop crisis centres) operated by the DSD which offer a continuum of services to survivors of all crimes and violence, and the Family Violence, Child Protection and Sexual Offences Units of the SAPS. These, however, are overwhelmed by access, capacity and funding limitations.

2.6.4.11 National Council Against Gender-based Violence

To deal with the difficulties of coordination and funding in the efforts to prevent VAWC, the South African government established the National Council Against Gender-based Violence (NCGBV) (Stop gender violence … 2014). First proclaimed in 2010, the council was established in December 2012 as a high level, multi-sectoral national response to the scourge of GBV to "lead and monitor the implementation of a 365 Days Plan of Action Against Gender-based Violence for Children and People with Disabilities" (South African Government News Agency 2012). More specifically, the objectives of the NCGBV are to offer strategic and political guidance to eradicate GBV by 2030; conceptualise and coordinate strategies for the development of coherent national plans and approaches to addressing GBV; form strategic partnerships to address GBV; build a platform for sharing information and best practices; monitor and evaluate the implementation of coherent national plans and strategies; ensure that all government departments commit satisfactory resources to combat GBV; and to engage with

business, CSOs and other role players to raise additional resources (Department of Women, Children and People with Disabilities 2013).

The most substantial of the objectives was the drafting and implementation of a national strategic plan (NSP) to combat VAWC (Sonke Gender Justice 2015). The NCGBV was to be commanded by the Minister of Women, Children and People with Disabilities, with a committed secretariat and 45 members representing the diversity of expertise, opinions and experiences of the various stakeholders (South African Government News Agency 2012). According to Sibanda-Moyo et al (2007), the membership of the NCGBV was to be representative of CSOs fighting VAWC, religious organisations, traditional leadership, the women's movement, academic and research institutions, and government agencies and departments. The council was also to permit observers from institutions such as the South African Commission on Gender Equality, agencies of the UN, donor partners and experts (Sibanda-Moyo et al 2007). The NCGBV met several times and in doing so finalised their vision and mission statement, established their framework for operation, developed strategies for the mapping of GBV hotspots, and advanced an NSP for GBV for the period 2014-2019 (Department of Women, Children and People with Disabilities 2013). However, implementation has not occurred. Sonke Gender Justice in its review of the present state of the NCGBV noted that it is "unfunded and unwanted … [there is] no word on the NCGBV, a Council ordered and created within the Presidency" (South African Government News Agency 2012). Thus, despite the increased activism across the country to mandate an NSP for GBV, the council has been unable to implement a strategy that is arguably critical in fighting the menace of persistent VAWC in South Africa. Bond & Mottiar (2013) pointed out that the deterioration caused by political changes and the privatisation of funding has been cited as the major challenges that were faced by the now non-existent council. Unfortunately, the impression created is that the council did more work before it was officially launched than afterwards.

2.6.4.12 National emergency response unit for victims of gender-based violence

In 2013 the DSD rolled out and now runs a technologically innovative 24-hour Gender-based Violence Command Centre (Department of Social Development Report 2014). The centre functions as a support and counselling unit for survivors of GBV through a toll-free number and empowers social workers to assist survivors via telephone and, should it be needed, to refer

them to social workers in the vicinity. The establishment of the centre is in line with the DSD's strategic emphasis on prevention and protection, response, care and support (Department of Social Development Report 2014) It is also a response to the insufficient access to social support services by GBV survivors. The centre is a response to the problem of extensive under-reporting of GBV due to the fear and shame experienced by victims when reporting face-to-face. According to the DSD, the Centre is "premised on the confidence that this service model provides help, hope and the chance of a better life to victims of gender-based violence, even in the remotest and most underdeveloped areas of South Africa" (Department of Social Development Report 2014). It is also framed as a model that empowers women who experience violence to acquire the psychosocial support needed to rebuild their lives. The centre has the capacity to handle over 1 500 calls per day (Mabena 2006).

In 2016 the DSD extended the centre to include the National Emergency Response Team (NERT) unit as a supplementary service commanded from the DSD's national office (Mabena 2006) This encompasses a mobile support service for VAWC survivors comprising social workers and psychologists specialised in trauma counselling and who provide services in private spaces for survivors including, where possible, their homes. As of November 2016, the centre had 48 social workers and eight other staff members who specifically targeted hearing-impaired survivors of VAWC. This enhanced centre empowers women and children with hearing impairments to easily access the services provided. It also deals with some of the vulnerability risk factors of VAWC, for instance, by equipping elderly women and women who commute alone with panic buttons to use in the case of emergencies. Through the NERT, the centre not only offers telephone services but can promptly deploy a specialised team to provide psychological and social support to all affected by the violence, debrief the trauma teams, and follow up and manage cases from their opening to finalisation (Mabena 2006). The team's work also embraces facilitating community dialogues and monitoring VAWC cases reported in the media to ensure immediate intervention. The principles of the NERT are commendable, and there is hope that its appropriate implementation will yield optimal results.

The study done by Barner and Carney (2011) divulged patterns in interventions from the 1980s to the present. The study showed that 90% of all current interventions for culprits were court-mandated as part of the criminal adjudication for charges arising from IPV. Furthermore, there were numerous psychotherapeutic interventions, group practice models, behavioural

intervention programmes and treatment for both perpetrators and victims. There is an ongoing debate in the literature regarding the effectiveness of interventions with the perpetrators of IPV.

2.6.5 Intervention programmes in dealing with intimate partner violence in Msinga

Noticeably little research has been done on IPV intervention programmes within the Msinga area. This is an important field to explore as it has the potential to be sustainable. The importance of having effective IPV intervention programmes has gained worldwide attention with the WHO (2013) endorsements stipulating that IPV services should, as far as possible, be integrated into existing healthcare services and structures.

As mentioned above, very little literature on intervention programmes dealing with IPV in Msinga has been found. However, the intervention programmes which do exist are carried out by local NGOs. Between 2014 and 2015, LifeLine Pietermaritzburg began what is arguably the first sustained programme to raise awareness of GBV in the rural communities within and surrounding the Msinga Local Municipality (Lifeline Pietermaritzburg and Motlafi 2017). According to Motlafi (2017), it was the many reports on *ukuthwala* and *ukulinywa* coming out of Msinga in 2013 that led to the LifeLine initiative.

The existing literature on IPV claims that even though IPV impacts all societies across racial, gender and class boundaries, women from poor socio-economic backgrounds are disproportionally affected. Chambers (2014) stated that the poor are those who are powerless to make their own choices due to physical weakness, isolation and limited access to finances, skills and knowledge. During the apartheid period in South Africa, government policy engineering meant that poverty affected more Black people than other racial groups. Black South Africans worked as labourers for low wages to provide for their families while engendering wealth for the White minority (Coovadia, Jewkes, Barron, Sanders & McIntyre 2009). South African society continues to deal with the legacy of apartheid. In 2017, for instance, 46% of Black African women were unemployed compared to 39% of the Coloured population, with Indians/Asians at 34% and Whites at 22% (Times Live 2017). Furthermore, several researchers have pointed out that female-headed households are more affected by poverty than male-headed households (Armstrong, Lekezwa & Siebrits 2008). This is consistent with national statistics that reiterate that unemployment affects more women than men across the country. The unemployment rate is higher among rural women than that of

women living in urban areas (Aliber 2003). It is in these contexts that one finds women enduring violation of their rights by their intimate partners. Paying attention to the effectiveness of the IPV programmes in Msinga will, therefore, assist the programme implementers in terms of what is and what is not working well and what is needed for further improvement. Some of the intervention programmes dealing with IPV in Msinga are described below.

2.6.5.1 Community responses

Matrimonial cases of IPV in Msinga are said to be handled within the family and decisions would be made by the elderly on behalf of both concerned parties. Alternatively, such cases would be dealt with in the local courts. Customary law, as generally observed, is based on the traditions and customs in a particular setting. However, these customary law courts have been identified as displaying a high and wide range of gender bias. The traditional perception of values is that women constitute a sector of society which has low status and are expected to be subordinated. As such, whenever a woman seeks to establish her rights, customary law would be very reluctant to appreciate her so doing (Sampa et al 1994). In many countries, particularly in remote areas, women are more likely to approach a community leader than a government official when they have a grievance (UN Women 2011). Nevertheless, community leaders resolve disputes according to local customs which barely safeguard women's interests. At the same time, as "custodians of culture", traditional leaders have the authority to modify customs and traditions to uphold women's rights and can thus be authoritative allies of women. There are several examples of local or community rights-based organisations commencing constructive dialogues with customary leaders on women's rights.

There is increasing consensus in violence prevention circles that men considered as the perpetrator should be part of the solution to put an end to domestic violence (Lang 2002; Ruxton 2004). Flood (2005) has identified many reasons for using men to end violence against women including men's attitudes are influenced by their male counterparts; men are seen as a credible source; male educators are looked upon as opinion leaders by other men by demonstrating respect for women; and men are knowledgeable about masculinity. There are intervention programmes in Msinga (and these will be discussed in the findings) that are increasing efforts to include men and boys in various capacities related to the prevention of violence against women, that is, as participants in education programmes, as targets of social

marketing campaigns, as policymakers and gatekeepers, and as activists and advocates (Flood 2011).

2.6.5.2 Community conversations

Participatory reflection drawing on human rights principles appears to play a critical role in bringing about collective change (UNICEF Innocenti Research Centre 2010). This has been well-documented in relation to the wide-scale abandonment of destructive practices like female genital mutilation (FGM) and early and forced marriage through abduction (such as the aforementioned *ukuthwala*). An exhaustive analysis of programmes that have led to the abandonment of FGM shows that they are most effective when they support community members to deliberate cooperatively on concerns and values within the community and link human rights principles to these local concerns and values (UNICEF Innocenti Research Centre 2010). In Msinga, there are NGOs conducting community conversations (also referred to as community action-oriented dialogues) facilitated by the local trained GBV ambassadors. GBV-related issues such as *ukuthwala*, *ukuklinya (Ukuklinya is a perverse practice; whereby a group of young men or boys strangle a young woman or girl up until she is loses consciousness. This 'ritual' makes the woman defenceless and vulnerable to be raped by her boyfriend or another male acquaintance)*, virginity testing, forced marriage and others are dealt with. However, there is no tangible evidence whether these conversations are effective in preventing and/or responding to IPV. The Msinga Local Municipality is unique and complex in terms of its environmental, social, economic, political and cultural context. Consequently, it is not a context in which one can simply just use "talk" as the intervention. Manifold deprivations of basic services, homesteads sprawled across mountainous terrain, weak road infrastructure, low levels of formal education, the omnipresence of violence, and aspects of Zulu culture that contradict constitutional values of individual rights have necessitated that LifeLine and Rape Crisis devote a large amount of time to getting to know the communities and receiving their buy-in, especially the buy-in of the local political and traditional leaders (Motlafi 2017).

Despite many efforts in eliminating IPV against women at international, regional and national levels, the problem has continued to escalate. Many perpetrators of IPV have continued to evade justice because few cases are being taken to court. Chuulu et al (2001) pointed out that while many cases of IPV are reported to the victim support unit in Lusaka's police stations, very few of them are prosecuted. Motlafi (2017) argued that the Criminal Law (Sexual

Offences and Related Matters) Amendment Act 32 of 2007 and the DVA 116 of 1998 are the two pieces of legislation that directly address GBV in South Africa. Usually, both these pieces of legislation are well-supported by gender activists and feminists as they both regulate the measures needed to effectively achieve the principle of gender equality, to curb incidents of GBV, to make perpetrators accountable, and to guarantee support to victims. Nevertheless, the foremost concern is with the application and interpretation of the legislation. It is still left to the discretion of the police to make sound determinations of whether a GBV crime has occurred and what is the minimum action required. Judges are required to interpret the law. Improving efforts to address IPV against women is critical not only because women have a right to live free from violence but also because violence incurs considerable social and economic costs.

It is noted, as mentioned above, that there are programmes implemented by various stakeholders attempting to combat IPV in KZN. However, there is little evidence in the literature of the effectiveness of these programmes and there is thus a need to add to the body of knowledge in this regard.

It is evident from the reviewed literature that some interventions show promise. Even though some programmes show promise, further research in this area is necessary. In particular, more high-quality, outcome-orientated studies are required to determine which programmes work, and for which populations. For example, while we have some qualitative evidence that survivors can access services through different organisations, further research is required to know to what degree these services lead to positive outcomes for the survivors and whether they are more effective for certain survivors. Knowing this, promotion and outreach can be better targeted. This literature review has highlighted other key areas for future research including further study on the effectiveness of interventions for both perpetrators and survivors of alcohol-related IPV, and psychotherapeutic interventions for survivors of homosexual IPV. More thought on the effectiveness of these interventions in rural areas will help to prioritise programmes and policies that diminish the trauma and suffering that many survivors of IPV face.

2.7 THEORETICAL FRAMEWORK

Two theories have inspired this study from its conception to its finish, namely, post-structural feminism and the socio-ecological model. They have been used not only to understand the risk

factors that affect women in the communities in which they live but also to consider what interventions they should undertake to address and reduce risks at the various levels.

2.7.1 Post-structural feminism

Post-structural feminism was used to focus on divulging the worst excesses of the social system in Msinga, namely, male supremacy and the need to identify and oppose it (Thompson 2001). Feminist theory is about viewing the social world in a way that exposes the forces that create and support inequality, oppression and injustice and, in so doing, promote the pursuit of equality and justice. Feminist theory is regarded by researchers as creative and inclusive because it considers how systems of power and oppression interact. Furthermore, the feminist perspective perceives IPV as the domination of women by men (Lawson 2012). This perspective claims that IPV can be restricted to issues of gender and power (Lawson 2012; Jewkes 2004; Yllo 1993) and manifests from the social pathologies of patriarchy. It demonstrates that society creates cultural constructions of gender that favour men and consequently may have debilitating effects on women (Suffla 2004) such as fear, injury, costly doctor consultations, and long-term physical and psychological consequences (Tracy 2007). According to Jewkes (2004), hierarchies of gender roles exist in these constructions which put men as superior and women as subordinate and of low value. These dissimilarities are extensive and negatively impact women's social standing, educational attainment, relationships and economic access, among other things. Hence, feminists strive for a society that treats both men and women equally in all spheres of life.

The post-structural feminist theory arose from the second wave of feminism in the 1980s and the 1990s (Seely 2014). It ascended from the need for a theory to analyse the manifestations of patriarchy and break the long traditions of Western philosophy that viewed the world in terms of masculine and feminine universals (Scott 1994). There was a necessity for a theory that would permit alternative ways of thinking about gender without simply reverting to old hierarchies or confirming them (Scott 1994). According to Seeley (2014:30), post-structural feminist theory is resolutely anti-categorical since it regards race, sex and other identities as social constructs resulting from domination. Thus, it aims to deconstruct the taken-for-granted historical structures of social organisations (Adams 1997). It also maintains that construction of the truths that govern the world has to be grounded in the diverse contexts of people's lives, communities and cultures (Adams 1997). Post-structural feminism is concerned with how

gender relations are constituted, reproduced and contested. It seeks to reveal patriarchal lineages and delegitimise their significance to society. It also aims at empowering people who are disadvantaged and to offer them new ways of understanding the world (Scott 2017). Therefore, it involves political action to understand and uproot causes of powerlessness, systems of oppression and women's complicity in them.

Essential to post-structural feminism are the concepts of language, subjectivity, social organisation and power and which try to understand why women tolerate social relations that subordinate their interests to those of masculine culture. Using post-structural feminism highlights the meanings, context and impact of violence. This perspective aims to demonstrate ways in which gender and sexuality are constitutive of dynamics (and not just outcomes). Its understanding of power uses a Foucauldian conceptualisation of power which operates in the field of relations. According to this understanding people, based on social location, use tactics and strategies available to them to negotiate dynamics of power. This Foucauldian model of power provides a context in which to understand how identities are produced and how people may use particular approaches and tactics to resist dominant forms of power (Cannon, Lauve-Moon & Buttell, 2015).

Moreover, the post-structural feminist theory claims that women in marginalised communities (such as Msinga) with no access to basic services are more vulnerable to oppression in the household, community and society than those from other contexts. It is in the light of this claim that Oyewumi (2002) argued that the feminist theory cannot be limited to gender oppression while overlooking racial and class oppression, since women do not share communal problems. Therefore, the post-structural feminist theory posits that women are not a homogenous group as they experience oppression in different ways. Based on this premise, Hooks (2000) called for the interrogation of the interlocking forms of domination to illustrate how gender interconnects with class, race and ethnicity to leave some women more vulnerable to oppression which, in the case of this study, is manifested in abusive intimate relationships.

Additionally, the post-structural feminist theory recognises that structural inequalities are rooted in institutions of power, which subject women to oppression in the household, community and society (Tong 2009; Moser 1993). Fundamentally, the theory recognises that women are not a homogenous group since some women are more oppressed than others (Oyewumi 2002). Thus, studies located in post-structural feminism aim to explore issues of

power, discourse, subjectivity and language. This post-structural concept of the interplay between power/knowledge/discourses and, ultimately, reality becomes critically significant when we utilise feminist theory to explore gender relations. This theory revealed that most rural communities that endure IPV, are artificially constructed through gender hierarchies that valorise, normalise and legitimise a masculine orientation of language. Nevertheless, and more notably, given the interplay between language, discourse and power in constructing our "intelligible reality", we can conclude that the historical and socio-political dominance of masculinity has undeniably defined and constituted our current "reality" (May 2015). Or, more specifically, that the current reality is governed by the discourses controlled by our temporal and spatially specific version of "hegemonic masculinity". This understanding was pertinent to the study which specifically focused on those variables considered relevant, namely, power, language, discourse and subjectivity. They resonated with the study the aim of which was to examine the effectiveness of the programmes being implemented to address the needs of women experiencing IPV in Msinga. The intersectionality of post-structural feminism as a theoretical framework was pertinent in the context of the study as it contributed to our understanding of the fundamental structural factors that drive IPV.

Given the above, the post-structural feminist concepts of power, language, discourse and subjectivity were used to investigate the experiences of women survivors of IPV in Msinga. According to Hester (2000), since the 1995 Beijing UN World Conference on Women, there are a burgeoning number of civil organisations that aim to defend female rights and people are paying more and more attention to the problem of IPV. Although tremendous efforts have been made, researchers are still debating what the crucial issues are.

2.7.2 Socio-ecological model

Socio-ecological models (SEMs) were advanced by the developmental psychologist Bronfenbrenner, the proponent of the systems thinking theory, to further the understanding of the dynamic interrelations among various personal and environmental factors. The theory hypothesises that to understand human development, the whole ecological system in which growth occurs needs to be taken into account. Systems thinking argues that the only way to completely understand an occurrence is to understand the parts in relation to the whole. Hence, the process of understanding how things influence one another is central to the ecological model. Since violence is a learned behaviour, the SEM can best enlighten the interactions

between the environment and the individual and it can also try to show the processes in human development that can influence one to be violent. Moreover, the systems and subsystems of the ecology can be better examined through the SEM lens to see how they influence the behaviour of an individual. Additionally, understanding how systems relate to each other is vital in the design of prevention programmes so that the problems are identified and dealt with accordingly. The SEM could better inform this study as it, the study, is about interpersonal violence and strategies for intervention. Furthermore, primary prevention strategies focus on individuals, communities and organisations and how they influence the behaviour of the individual. This model best guided the study in terms of the study's focus on human and relationship characteristics that promote healthy intimate relationships.

The SEM also highlights the importance of understanding the complex interplay of biological, psychological, social, cultural, economic and political factors that increase women's likelihood of experiencing violence (and men's likelihood of perpetrating violence). Using the model can help service providers shift from individualistic service delivery to a more holistic approach to service interventions that not only target individual specific needs but also address the need for social change. The model is also ideal for understanding the factors influencing IPV. It, therefore, also helped to address objective four of the study which aimed at improving prevention programmes to address IPV at all levels. Previously, the Centre for the Study of Violence and Reconciliation's (CSVR) gender programme primarily engaged with secondary and tertiary GBV prevention strategies. On a national scale, many research projects, public awareness campaigns, policies and programmatic interventions have been formulated and some have been implemented by various role players. In terms of the SEM, responding to GBV including IPV after its occurrence incurs substantial social, health and economic costs to society as well as to the directly or indirectly affected individuals. Henceforth, the strategies discussed here emphasise the importance of employing primary prevention interventions alongside secondary and tertiary ones. For primary prevention, interventions should aim at addressing violence before it occurs, for instance, by addressing behavioural issues or managing the impact of risky environments on the Msinga community members. These primary interventions might focus on education, empowerment, developing self-respect and self-esteem, and decreasing social isolation among women in Msinga. These prevention activities with women would be integral to effective approaches.

Secondary prevention interventions focus on immediate responses to violence, often in a crisis situation. It is often thought of as applying to individual victims and perpetrators but the concept has wider applicability (WHO 2010). For survivors, it intends to reduce the short-term harms of violence, as well as the risk of re-victimisation. According to the WHO (2010), secondary prevention might include, for example, emergency services or treatment for STDs following a rape. For perpetrators, secondary prevention can comprise interventions aimed at preventing the escalation of violent behaviour. These are also known as indicated interventions (WHO 2010). Furthermore, they can include actions such as training professionals in providing crisis responses to victims and survivors or measures to ensure optimal accountability of those who have the duty to protect victims and survivors of violence (Rutherford et al 2006).

Tertiary prevention interventions, on the other hand, focus on long-term care in the wake of violence, such as rehabilitation and reintegration of perpetrators, and attempts to lessen trauma or reduce the long-term disability associated with violence. Examples of the latter are psychological therapies for abused children, and screening and support services for victims of IPV (WHO 2010). At the tertiary prevention level, indicated interventions for perpetrators mainly focus on high-risk individuals who have detectable problems, such as sex offenders. Secondary and tertiary prevention interventions are considered as having relevance for victims and perpetrators in judicial settings as well as healthcare and wider social settings. The interventions use the SEM which emphasises primary, secondary and tertiary prevention efforts at different points.

The primary, secondary and tertiary prevention interventions incorporate several inter-related dimensions about when interventions happen, who the target audiences are, what the interventions are aiming to achieve, and the forms of activities undertaken (Quadara and Wall 2012). Furthermore, prevention programmes need to encompass all three levels so that they can be mutually reinforcing, with each increasing the effectiveness of the other (Fergus 2012). The socio-ecological theory thus helps provide specific answers to how individuals, families and communities can be instrumental in either influencing violence or preventing it by showing the connection between cause and effect. Systems such as traditions, cultures and norms in the society can perpetuate issues of violence or disrespect for women and thereby shape individuals within that particular society to behave in a way that degrades women.

Research indicates that IPV is usually experienced by women at the hands of men (Westbrook 2009; WHO 2012; Tjaden & Thoennes 2000). Nevertheless, IPV is not unique to heterosexual relationships. Power differences that frequently accompany heteronormative gender scripts (often cohering around masculine "butch" and feminine "femme" lesbian identities) contribute to IPV in same-sex relationships (Lynch & Sanger 2016). Heterosexist norms contribute to relationship dynamics that focus on control and coercion (associated by participants with butch identities) and vulnerability and victimhood (associated with femme identities). These discoveries demonstrate the patriarchal context in which normative gender identities and roles are created in South Africa, and in particular the harmful ways in which "toxic" masculinities can manifest in violent relationships (Lynch & Sanger 2016).

Social norms, which are shared expectations of specific individuals or groups concerning how people should behave, incline to promote control of men over women. There is considerable research which suggests that a variety of social norms and beliefs associated with gender and family privacy contribute to physical and sexual violence (Heise 2011). Customs or norms act as powerful motivators either for or against individual attitudes and behaviours, mainly because individuals who deviate from group expectations are subject to shaming, sanctions or disapproval by others who are significant to them (Heise 2011). These social constructions do not function in a vacuum but are reinforced by dominant social patriarchal patterns together with traditional perceptions of masculinity, privacy, the sexual objectification of women, and heavy alcohol use (De Keseredy et a, 2006).

Several studies done in South Africa have endeavoured to establish the possible reasons for men to perpetrate violence in their intimate relationships. Some of the findings claim that men become perpetrators of violence following exposure to violence within their own families and communities (Abrahams et al 2006; Collins 2013). Other studies have found that men are socialised into violence by the agents of socialisation immediate to their social contexts, namely, family, culture, community and peers (Wood & Jewkes 2001; Jewkes & Morrell 2012). It is for these reasons that violence is normalised and men and women learn stereotypical views of how they should behave in society and their intimate relationships (Boonzaier & de la Rey 2004; Lau 2009). When intimate partners fail to meet the gender norms that are prearranged in society, violence becomes a mechanism to police this failure (Jewkes 2002; Abrahams et al 2006). Research has also acknowledged threats to masculine ideals (such as feelings of powerlessness due to unemployment, poverty or being uneducated) as contributing

factors to violence within intimate relationships (Boonzaier & De la Rey 2004; Wood & Jewkes 2001).

Researchers state that patriarchal values and structural gender inequality are implicated in violence against women (Boonzaier & De la Rey 2004; Wood & Jewkes 2001). Gender roles that are strengthened in homes, schools and broader society in South Africa support male dominance and female subordination, making women more prone to victimisation than men (Barkhuizen 2013). A question often asked is why women remain in abusive relationships. According to Jewkes (2002), many women endure IPV because families and communities stress the importance of maintenance of the male-female union at all costs. These perspectives work together to defend men's dominance and abusiveness and women's victimisation by socialisation and the acceptance of cultural norms as fixed and unquestionable (Jewkes 2002).

Attitudes that women, their families and society embrace play a substantial role in the perpetration of IPV and ultimately the victimisation of women. The fairytale that women are to be blamed for their own victimization has long been rejected by researchers who claim that a victim's behaviour is not the reason for the violence perpetrated against them (Boonzaier & De la Rey 2004; Flood 2014; Hayes 2015). The belief that women are to be blamed gives power to the perpetrator's defence for the violence and its possible escalation. It is noted that women who embrace more traditional gender-role attitudes are more likely to accept IPV against women (Flood 2014; Jewkes 2002). These normative gender-roles are found mostly in rural areas where men are highly dominant. Women living in rural areas largely come from poor backgrounds and face many economic challenges. Poor economic circumstances are one of the main reasons for rural areas being cited as common places for IPV against women in the broader society.

As applied to IPV, the ecological framework has been viewed in several ways all of which share the notion of embedded pathways of causality. Heise (2011) stated that women bring to their relationships a genetic endowment, certain personality traits and a host of experiences from their childhood and adolescence. They partner with men who, in a similar vein, bring personal histories and in-born proclivities to their union. The couple is then in a relationship that has its own dynamics, some of which may escalate or reduce the risk of violence. Furthermore, the relationship is embedded in a household and neighbourhood context that affects the potential for abuse. In many low-income settings, especially in rural areas, this

includes the influence of extended family members who interact with the couple in ways that may either escalate or decrease the chances of violence. Also, both partners are involved with several different communities including those related to work, friendship networks, faith communities and governance structures. This is known as a mesosystem in the original ecological model suggested by Bronfenbrenner. The entire system is entrenched in a macro-system which refers to the cultural, economic and political systems that inform and structure the organisation of behaviour at the lower levels of the social ecology.

Ecological thinking signified a noteworthy step forward in the field of violence studies because it hypothesised the causes of violence as probabilistic rather than deterministic (Heise 2011). In other words, influences operating at different levels converge to create the likelihood of violence occurring. No single factor is adequate, or even necessary, for IPV to happen. There are probably different constellations of issues and pathways that may converge to cause violence in different situations. Likewise, a similar set of genetic, personal history and situational factors (such as abuse in childhood, a proclivity toward impulsiveness, and having too much alcohol) may be sufficient to push a particular person toward IPV in one socio-cultural and community setting but not in another. One can assume that a man's response to "perceived" provocation may be quite different based on what his expectations are regarding male or female relations; whether his friends, neighbours and local authorities are likely to find his behaviour "acceptable" or shameful; and whether his partner has the social authorisation and economic means to leave him if he crosses the line (Heise 2011).

Numerous researchers have tried to summarise what is known about issues that appear salient for IPV at the different levels of the ecological model. The original effort in this regard, published by Heise (1998), was forced to rely primarily on risk factor studies emanating from high-income countries. It was complemented with findings from ethnographic case studies of partner violence in low-income countries and several quantitative studies that excerpted and collated variables from ethnographic accounts of marginal societies archived in the Yale Human Area Relations Files (Levinson 1989). Various versions of the ecological model still reproduce influences noted in this early publication, although the research base has been significantly enriched since then.

Mellor (2018) correctly argued that it is impossible to understand the ecologically destructive consequences of dominant trends in human development without understanding their gendered

nature. The SEM, together with the post-structural feminist theory, would strengthen the capacity of women, NGOs and CBOs to carry out local advocacy initiatives in the Msinga community as well as expose and avoid gender injustices and traditional, cultural and religious practices that discriminate against and violate women's rights. The two theories were used to understand the issues faced by women experiencing IPV in Msinga and to propose policy recommendations for handling such IPV cases.

2.8 CONCLUSION

This review of the literature has shown that IPV is a global social problem of epidemic proportions for women in particular. The weighted mean global occurrence of IPV is estimated at 30% and may be a valuable tool for policymakers. The global mapping of IPV may also be informative for researchers and service providers working at a regional or country-level given the wide heterogeneity of prevalence. As it is apparent that some areas have meaningfully higher risks of IPV, service providers are encouraged to take direction from regional-level data where possible. There are some limitations in the evidence base of IPV and current strategies to combat it are faced with numerous challenges which make IPV prevalence estimates less precise.

Indeed, researchers are only able to measure the number of people willing to unveil abuse as opposed to the number of people facing it. As such, there is the danger of under-reporting (Alhabib et al 2010). Also, definitions of abuse, violence and blame are highly variable and culturally sensitive (Krauss 2006). There is also the possibility that some women facing abuse are likely to justify the violence against them (Fagan & Browne 1994). Given this, it can be difficult to construct questions that can sympathetically and precisely establish the presence of IPV in cultures. What is clear is that IPV is found to most commonly affect women, particularly women in rural areas. High rates of IPV are thus frequently found to be geographically located and they are often co-located with the HIV epidemic, and this is often the case in South Africa.

A significant development in terms of intervening to prevent and respond to IPV against women in Msinga is that of LifeLine, Pietermaritzburg. Funded by the Global Fund, the organisation has invested an extraordinary amount of effort over the years in the prevention of VAWG in Msinga. As Motlafi (2017) points out, LifeLine Pietermaritzburg has initiated what

is arguably the first sustained programme in Msinga to raise awareness of GBV, to address the underlying causes of violence and to stop it from occurring.

This study used post-structural feminism and the SEM as theoretical underpinnings to further understand what intervention programmes should be undertaken in Msinga to address and reduce IPV risks at the different levels. According to Dahlberg et al (2011), violence is complicated and results from a multiplicity of behavioural influences. Likewise, there are several overlapping and inter-related models that have been used globally and that are important for those working in the social sector to know and understand.

CHAPTER 3

RESEARCH METHODOLOGY AND METHODS

3.1 INTRODUCTION

In the previous chapter, Chapter 2, I reviewed the literature and discussed the theoretical framework that supported this study. In this chapter, I deliberate on the research design and methodology used to conduct the study. I first discuss the research paradigm and design that guided this study. This is followed by a discussion of the qualitative methodology adopted as a means to gain an in-depth understanding of the topic under study. The sampling method, demographic information about participants, and data analysis used to generate findings are clarified and justified. The chapter also outlines and discusses the ethical considerations of the study as well as the trustworthiness of the study's findings. The challenges experienced during the fieldwork are then delineated and the chapter ends with the limitations of the study and a conclusion.

3.2 RESEARCH PARADIGM

Babbie (2011) described a paradigm as the structural model or frame of reference we utilise to organise our observations and reasoning. This study was couched within the interpretivist paradigm. Cohen, Manion and Morrison (2011) indicated that the interpretivist paradigm's primary concern is to comprehend the subjective world of human experience and to derive meaning from shared experiences. According to Bertram and Christiansen (2014), the interpretivist paradigm's purpose is to develop a better understanding of how people make sense of contexts in which they live and work. Meaning can only be assumed in the interaction between the researcher and the participants (Creswell 2009). Cohen et al (2011) argued that the interpretivist paradigm has the following characteristics: it focuses on the individual, involves small-scale research, is subjective and qualitative in nature, is hermeneutic and interpretive, has multiple directions of causality, necessitates personal involvement of the researcher, aims at understanding actions or meanings rather than causes and investigates the taken-for-granted. Researchers using this paradigm focus on the specific context in which people live and work (Creswell 2009). This study was concerned with examining the

effectiveness of programmes being implemented to address the needs of women experiencing IPV in Msinga.

3.3 RESEARCH DESIGN

Bertram and Christiansen (2014:40) refer to research design as "a plan on how the researcher will systematically collect and analyse the data that is needed to answer the research question." This research was an empirical study that used primary data. It adopted a qualitative research paradigm. The qualitative strategy allows for one-on-one or group discussion and also allows the interviewees to express their own opinions. Follow-up questions on the part of the interviewer provide him/her with the opportunity of "going deep" into the subject. This is encouraged as it gives insight into what the interviewees see as relevant and important information. Such a strategy assisted me in getting detailed and rich information particularly from respondents who were "traditionalists" and who could not read and write (Bryman & Bell 2007). This study utilised a descriptive design as per Babbie and Mouton (2001) who confirmed that qualitative researchers have always been concerned with describing actions.

3.4 RESEARCH METHODOLOGY

The methodological orientation, the research parameters within which the data were generated, and the research instruments that were used to generate data are discussed below.

In line with the qualitative nature of the study, the two methods of data collection used were in-depth interviews and focus group discussions. According to Ritchie and Lewis (2003), qualitative methodology is a naturalistic, interpretative approach concerned with understanding the meanings which individuals attach to actions, decisions, beliefs and values within their social world. It is also concerned with understanding the mind mapping process that respondents use to make sense of and interpret the world around them. Holloway (1997:2) defined qualitative research as a form of social inquiry that focuses on the way people interpret and make sense of their experiences and the world in which they live. While several different approaches are found within the wider framework of this type of research, most of them have a similar aim, that is, to comprehend the social reality of individuals, groups and cultures. Researchers use qualitative approaches to explore the behaviour, perspectives and experiences of the people they study. Qualitative methods habitually depend on text, images, and direct

interaction between researchers and participants. In addition, they include the researcher seeing the participants behave and act within their context.

In line with Creswell (2014), I concentrated on Msinga women that have experienced IPV in their lives and who have received interventions from the four targeted organisations providing IPV services. The investigation was based on the Msinga women's understanding of IPV, its prevalence, how it can be reduced in their homes, and their perspectives on the IPV programmes available in Msinga and how they can be improved. As specified above, this study was grounded within the interpretive paradigm and adopted a qualitative approach. My aim of obtaining the in-depth views of the participants located the study well within such a paradigm and approach as both are appropriate for studies seeking rich, in-depth data. The study intended to unfold meanings and interpretations that the women and the IPV programme implementers (that is, members of staff in the four organisations) assigned to IPV in Msinga. The qualitative approach was thus appropriate and useful for the study because it revealed in-depth and insightful information concerning the participants' experiences of the IPV programmes in Msinga. The research methodology that was adopted allowed participants to express themselves meaningfully and subjectively in a private, confidential and non-judgemental environment.

3.5 SAMPLING METHODS AND SAMPLE SIZE

3.5.1 Sampling methods

Purposive sampling is used to select cases with a specific purpose in mind (Neuman 2007). Participants in the study were selected based on their knowledge and experience in the field. A second type of sampling is convenience sampling. According to Dawkins (1991), as cited by Sukhraj-Ely (2009:5), convenience sampling entails choosing individuals that the researcher can easily access. As pointed out above, the first set of interviews was with the key informants, namely, eight members of staff from the four organisations that had been identified as dealing with IPV in Msinga. The second set of interviews was held with 32 women survivors of IPV in Msinga. They were randomly selected based on the services they had received from the organisations and on the different timeframes the services were provided. Assistance in this regard was given by the management of the four organisations. Once the women had been

identified by the participating organisation, they were then approached by me to participate in the study. Almost all the women survivors approached agreed to participate but two of them did not come for the interview and they were replaced by others. Thus, as per Babbie and Mouton (2001), the participants were easily identified as they were specific "elements" of a larger population of women who had experienced abuse by their intimate partners.

3.5.2 Sample size

The first set of individual interviews was with participants from the four NGOs, namely, LifeLine and Rape Crisis, the Khayelisha Care Project, the Snozwelo Resource Centre and the uMusa woMsinga under the Noyibazi Clinic, that had been identified as working with survivors of IPV in Msinga. Permission letters to conduct the study were obtained from the organisations. There were eight participants, two from each organisation, comprising an executive director (1), a GBV project manager (1), social workers (2) (one of whom was a social auxiliary worker), and community care workers (2) and lay counsellors (2) (See Table 2 below). These eight participants were considered as key informants since they were all involved, in some capacity, in dealing with IPV and the organisational approaches used in doing so. The basic or second set of interviews was held with 32 women participants between the ages of 18 and 35 years. They were all survivors of IPV and had received services from the above-mentioned organisations. They were interviewed to ascertain the approaches used during the interventions and to find out if their circumstances had changed. In patriarchal areas such as Msinga, most women enter into marriage and intimate relationships at a very young age; hence, I decided to focus on those women between the ages of 18 and 35 years. Furthermore, it was anticipated that this age group would be more willing to share their experiences in terms of the IPV services they had received from the organisations as opposed to older women who might still regard IPV issues as an intensely private matter. Padgett (2008) stated that the sample size in qualitative research is focused on flexibility and depth rather than numbers. The smaller the sample size, the more intense and deep the data being collected is likely to be.

Thus, the first set of interviews were with two key informants from each of the four organisations to ascertain, amongst other things, how they dealt with cases of IPV. The second set of interviews were with 32 women survivors of IPV who had received services regarding IPV from the four organisations. Interview guides were established and translated into the local language (isiZulu) to ensure participants understood the terminology. Arrangements for

interviews were made telephonically. Two focus group discussions were also held with those participants willing to take part. The one group consisted of eight participants and the other, 10 participants. The former comprised the staff from the identified organisations and the second the survivors of IPV who had earlier undergone individual interviews and had agreed to participate in a focus group discussion. It is not uncommon to think that one focus group will be enough to collect sufficient data. Using two focus groups ensured that data was gathered from the perspectives of both the staff who were implementing IPV programmes and the women survivors who were the recipients of the programmes. Furthermore, the focus groups were used to triangulate the responses from the individual interviews and further explore the key themes that had emerged from the interviews and required elaboration. In this regard, Greeff (2005:299) stated that "focus groups are the means to better understanding how people feel or think about issues or services". In addition to the interviews and group discussions, documents such as gender policies and the organisations' mandates and strategic plans were analysed to identify their policy directions on IPV issues.

3.6 RESEARCH METHODS

3.6.1 Data collection methods

To examine the research questions and as noted above, semi-structured face-to-face interviews and two focus group discussions were used as data collection methods. Bertram and Christiansen (2014) state that interviews are used extensively in interpretivist research as they intend to explore and describe people's perceptions and understanding of what might be unique to them. Interviewing is also advantageous for gaining detailed insights from a small number of people (Newton 2010). The interviews for the key informants (that is, staff employed in the four organisations involved with IPV) were conducted in English and sometimes translated into isiZulu when it seemed that the participants did not understand the questions asked. The basic interviews with the women who had experienced IPV were conducted purely in IsiZulu as they were all Zulu speakers. During the interviews, much probing was done to dig deeper into matters of concern and to reach consensus on issues. Data were generated over a period of four weeks – two days for the focus group discussions, three days for the key informants and three weeks for the interviews with the women IPV survivors. The four weeks allowed for the

collection and organisation of the data to be effectively conducted. The interviews and discussions were audio-taped and I also kept a journal to record necessary information to ensure that the voices of the participants and other details in my interactions were not lost.

It is acknowledged that how women may understand IPV programmes is multi-layered and could only be understood from the meanings that the women attach to them. As noted, I interviewed the women that had experienced IPV and the staff involved in implementing the IPV programmes. They provided their understanding of IPV according to their different life experiences. The programme implementers also provided their in-depth understanding of how their programmes were combatting issues of IPV in Msinga. In total, I got to interact with 40 participants and of these, eighteen interacted with each other in the focus group discussions. The participants' interaction in the focus group discussions provided high-quality data as they reacted to and built on each other's experiences. The meanings and interpretations derived from the individual interviews were very individualistic. As Cohen, Manion and Morrison (2011) observed, within the interpretivist paradigm, people's realities are subjective.

3.6.2 Individual interviews

Once I obtained permission to conduct the study, the four identified organisations were telephonically approached to confirm their participation. A pilot interview was first conducted with five colleagues in the field of GBV to establish whether the questions asked were going to be suitable for the interviews. The semi-structured interviews were conducted before the focus group discussions. They were held to elicit information from the women IPV survivors and the IPV programme implementers. The interviews were, in particular, directed at those that did not wish to partake in the focus group discussions, thus avoiding possible domination by others or being constrained by the presence of others. The individual interviews were also conducted for their in-depth and richness of data especially when combined with the data generated through the focus group discussions. Furthermore, research has revealed that data gathered through individual interviews can be merged with focus group data to complete and confirm data (Halcomb & Andrew 2005). Semi-structured interviews are most suitable where there is little knowledge about the study phenomenon and for exploring sensitive topics where respondents may not want to talk about such topics in a group environment (Gill, Stewart, Treasure & Chadwick, 2008). Some participants wanted me to come to their homes as they were comfortable with being interviewed there. However, there were other participants who,

due to issues of confidentiality, were not. To maintain their safety and privacy, interviews with these participants were conducted in the organisations' offices. This was done on the understanding that some participants would not talk freely in a group. The reality is that IPV survivors talk more when they are alone than they would do as part of a group.

The individual interview questions (see Appendix B) were formulated and categorised in terms of the four key research questions listed in Chapter 1. As mentioned, the participants mostly spoke in their native language, IsiZulu, since all of them communicated better through it. The responses were subsequently transcribed and translated into English. The transcription was done by myself as isiZulu is my mother tongue. Doing so ensured that the process of transcription and translation was promptly done and the integrity of the responses, in terms of accuracy of the translations, was maintained.

3.6.3 Focus group discussions

As noted above, focus group discussions (also referred to as focus group interviews) were conducted after the individual interviews. Cohen et al (2011:436) stated that "Focus groups are a form of group interview whose reliance is on the interaction within the group who discuss a topic supplied by the researching, yielding a collective rather than an individual view." Two focus group discussion sessions were conducted to ensure that clear patterns emerged and that subsequent groups produced no new information (Krueger 1994). The focus group discussions were utilised to comprehend the women's construction, notions and interpretation of IPV. Furthermore, the discussions were used to obtain indigenous knowledge based on Msinga's traditions, culture and norms. A video by Matlakala (2012) portraying violence against women in societies was played before the start of the discussions. This was done to prompt discussion among the participants. As Jewitt (2012) pointed out, the use of video in focus groups is useful because it prompts discussion, stimulates recall of memories and experiences of the participants, and offers a basis for reflection. With the permission of the participants, an audiotape was used to record the discussions and transcription of the tape was done afterwards. Audio-tape recording made certain that the exact words of the participants were captured thereby strengthening the trustworthiness of the study. The focus group discussions were held at two organisations: the Khayelisha Care Project and the Snozwelo Resource Centre offices. Choice of the venues was driven by the needs of the participants. As Smith (1972) has argued, when researchers choose the meeting venue, they must take into consideration participants'

comfort, access to the venue, and levels of distraction. Also, participants should be in a normal and familiar setting with sufficient space for different activities within the focus group discussion session to take place.

The rule of thumb for the length of focus group discussion is one to two hours and depends on the complexity of the topic under investigation, the number of questions and the number of participants (Carlsen & Glenton 2011). The age of the participants, for example, younger school-going children, also plays a role in terms of the length of the focus group session (Gibson 2012; Heary & Hennessy 2002). The two focus group discussions (see Appendix A) took approximately one hour and 50 minutes each. I did not have refreshments to provide to the participants and they were likely to have suffered from fatigue should the discussions have gone on for longer.

As noted, two focus group discussion sessions were held – the one consisting of eight participants and the second, 10 participants thus making the discussions manageable. The first focus group discussion was held with the members of staff (key informants) from the four NGOs sharing their perspectives on the IPV programmes employed in Msinga, while the second discussion was with the women survivors sharing their experiences of IPV in Msinga.

3.7 DEMOGRAPHIC INFORMATION OF PARTICIPANTS

3.7.1 Msinga women survivors of intimate partner violence

Below, I provide brief demographic information concerning the 32 women survivors of IPV who participated in the study. The information was shared during the individual interviews and affords an understanding of their context and background. This is followed by brief descriptions of the four organisations whose work involved providing services related to IPV in Msinga (see Chapters 4 to 7). The participants home language was isiZulu, they were all of African descent and hailed from Msinga in KZN. The names of the participants below are pseudonyms which were used to protect their identities as per the ethical requirements of the study.

1. Zamile was a 19-year-old woman from the Bathenjini community in Msinga and was currently receiving services from the Khayelisha Care Project. She had lived in Msinga since birth. She

had a fiancé whom she trusted with her life. She felt safe with him, regardless of what had happened in their lives. Zamile's highest grade passed was grade 8. She was unemployed.

2. Celimpilo was a 32-year-old woman from the Pomeroy community which is part of Msinga. She has been a client of the Khayelisha Care Project since 2017. She was born and bred in Msinga. Her last grade passed was grade 10. She was married under customary law and blessed with four boys. She was unemployed.

3. Ngenzeni was a 28-year-old woman from the Gudwini community. She was cohabiting with a 58-year-old man. Her last grade passed was grade 9. Both she and her partner were unemployed and finding it hard to provide for their three children.

4. Funani was a 34-year-old woman from the Mvundleni area. She was admitted to the Khayelisha Care Project for personalised care. She had been in the shelter for the past five months. Her last grade passed was grade 11. She had two daughters and two sons that were currently cared for by their maternal grandmother who was a pensioner.

5. Hleziphi was a 29-year-old woman from the Nhlesi area. The last grade she passed was grade 11. She had two daughters and was staying with her fiancé who took care of her in terms of basic needs as she was unemployed.

6. Thokozile was a 20-year-old woman from the Sphongweni community. Her highest grade passed was grade 9 during which time she fell pregnant. Her biological parents disowned her and she was taken in by her boyfriend's family. The boyfriend is working in Johannesburg and only comes home twice times a year. She survives doing piecemeal jobs in er neighbourhood such as ploughing and washing for other families.

7. Khathazile was a 35-year-old woman from the Nyonini area. Her last grade passed was grade 10. She was employed on a local sugarcane farm where she worked three days a week and was paid fortnightly. She had three children, two boys and one daughter and was in an arranged marriage.

8. Jezile was a 35-year-old woman from the Mshazafe community. Her highest grade passed was grade 11. She had four children and one grandson and stayed with her in-laws. She was employed in a local supermarket as a general worker. She was married under customary law after having been abducted by her current husband and his brothers. She has learnt to love her

husband following the abduction. However, she did not wish the same thing to happen to her daughters.

9. Khanyisile was a 26-year-old woman from the Mahlabathini area. Her highest grade passed was grade 12 but with a higher certificate. She wanted to upgrade her subjects but could not since she did not have money to further her studies. She was now staying with her fiancé who was employed as a taxi driver. She had two daughters.

10. Nomthandazo was a 31-year-old woman from the Mabomvini community. Her last passing grade was grade 9 after which she fell pregnant. She had three sons and was residing with her in-laws after her biological parents disowned her. The biological parents had demanded the bridewealth (lobola) from her boyfriend but he could not pay as he was not working at the time. This resulted in Nomthandazo's family disowning her.

11. Ntombizonke was a 28-year-old woman from the Mabomvini community. Her last grade passed was grade 11. She had two children. The first child was an unplanned one since she was raped by her current boyfriend. The second one was planned as they both wanted to enter into marriage. Unfortunately, this did not materialise as the boyfriend was retrenched from his job in a coalmine in Dundee.

12. Velephi was a 31-year-old woman from the Mahlabathini area. Her highest grade passed was grade 10. She sadly had four miscarriages in two consecutive years. She stayed with her in-laws. Her fiancé was employed and was the breadwinner at home. She was in a polygamous marriage being the second wife.

13. Ntombikhona was a 33-year-old woman residing in Nyonini area. Her highest grade passed was grade 11. She had two daughters and one son. She was working as a cashier in a supermarket in Tugela Ferry and was residing with her husband.

14. Thembani was a 20-year-old woman residing in the Mathenjini area. Her highest grade passed was grade 10. She had one child, was unemployed and was staying with her fiancé's family.

15. Thenjiwe was a 27-year-old woman residing in the Mshazafe community. Her highest grade passed was grade 9. She had two sons. Her first fiancé had sadly passed on and the brother of the fiancé had to take over. She was now in a relationship with the brother. Anthropologists refer to this kind of marriage as levirate. This is a traditional requirement that other families in Msinga are still expected to adhere to.

16. Kholiwe was a 24-year-old woman staying in the Mvundleni area. Her highest grade passed was grade 12. She was married under customary law and had one son born before the marriage. She lived with her in-laws while the husband stayed in Johannesburg for work-related reasons.

17. Zinhle was a 25-year-old woman staying in the Sphongweni community. Her highest grade passed was grade 11. She had a fiancé whom she was forced, by her circumstances, to fall in love with. She had two children of her own and was supported by the fiancé as her parents had passed on.

18. Lindiwe was a 23-year-old woman from Gudwini community. Her highest grade passed was grade 12. She had two children. Her fiancé was in the process of paying her lobola. She was pregnant with a third child and was unemployed.

19. Ntombikayise was a 28-year-old woman from the Pomeroy area. Her highest grade passed was grade 11. She had three children and resided with her fiancé's family. She was also in a polygamous marriage being the third wife.

20. Londiwe was a 32-year-old woman from the Nyonini area. Her highest grade passed was grade 9. She had a son and a daughter and was in the process of getting married. She was temporarily employed as a general worker at the local B&B.

21. Snegugu was a 21-year-old woman staying in the Nhlesi area. Her highest grade passed was grade 11. She had one child and was taking driving lessons as her fiancé owned a local driving school. She was staying with her in-laws.

22. Thobekile was a 31-year-old woman from the Tugela Ferry area. Her highest grade passed was grade 11. She had two children. She was qualified as a community care worker but was struggling to secure employment. In the interim, she was volunteering her services at one of the CBOs in the area. She was married to a pastor.

23. Cici was a 33-year-old woman coming from the Mahlabathini area. Her highest grade passed was grade 11. She had three children, two boys and one girl. Cici was unemployed at the time of the interview and resided with her fiancé.

24. Bongiwe was a 32-year-old woman from the Mabomvini community. Her highest grade passed was grade 10. She was employed by the Expanded Public Works Programme (EPWP) and had

been working for the programme for the two past years. She was married but unfortunately unable to conceive. She was the breadwinner in the household as her husband was unemployed. She looked after her husband's three children that he conceived outside the marriage. Since she was not able to conceive, she was forced to accept the husband's second wife.

25. Nonhlanhla was a 24-year-old woman from the Mahlabathini area. Her highest grade passed was grade 10. She had one child and stayed with her mother as the mother was old and unable to take care of herself. Nonhlanhla also needed to take care of her fiancé who was critically ill. To do so, she had to resign from work. They were dependent on the child support grant in respect of their child.

26. Duduzile was a 35-year-old woman from the Mabomvini community Her highest grade passed was grade 9. She had two children and one grandchild. She was volunteering in the nearest crèche as a childminder. The parents of the children she looked after give her different gifts such as clothes, bags, shoes and food to eat in return for taking care of their children. Her boyfriend would also get some piece jobs but was hardly able to provide for the family

27. Zothile was a 30-year-old woman from the Pomeroy area. Her highest grade passed was grade 10. She had three sons and their father had sadly passed on. She now has a boyfriend. Zothile survives via the child support grants received for her sons. She stayed with her paternal grandmother as her parents' whereabouts were unknown to her.

28. Zamile was a 23-year-old woman residing in the Mathenjini area. Her highest grade passed was grade 11. She had two children and grew up with her maternal family in the absence of her biological parents. Her father was said to have gone to Johannesburg to look for employment but never came back. The mother followed to look for her husband and also did not come back. Zamile stayed with her boyfriend and the two children.

29. Nompumelelo was a 33-year-old woman from the Tugela Ferry area. Her highest grade passed was grade 10. She had three children of her own and two from the husband which he had before they got married. She stayed with her husband's extended family and was unemployed.

30. Tholakele was a 31-year-old woman from Mshazafe community. Her highest passing grade was grade 08. She had two girls. She was not employed as she had to look after her two children that had special needs. She survived on the care dependency grants in respect of her two children. Her husband was deceased.

31. Nomalanga was a 25-year-old woman from the Mshazafe community. Her highest grade passed was grade 11. She had two children and was employed as a domestic worker. She stayed with her fiancé who was employed as a truck driver.

32. Nomithi was a 20-year-old woman from the Sphongweni community. Her highest grade passed was grade 11. She had one daughter and stayed with her boyfriend's. The boyfriend stayed in Newcastle where he worked. Nomithi was disowned by her family after she got pregnant and the boyfriend was unable to pay for the damages. Nomithi said that her family would only accept her back once the boyfriend owned up and paid for the damages. According to the family, the ancestors were angry as things were not done according to tradition. Had her father kept her in the family, he would have continued to lose his livestock and, like cursed people, bad luck would have continued to follow him.

Table 1 below reflects the participants in terms of the organisations they were associated with and their age.

Table 1: Women survivor participants by organisation and age

Organisation	*No. of participants*	*Age between 18 and 25*	*Age between 26 and 35*
Khayelisha Care Project	8	4	4
uMusa woMsinga Project	8	1	7
LifeLine and Rape Crisis	8	5	3
Sinozwelo Resource Centre	8	2	6
Total	32	12	20

3.7.2 Profile of the non-government organisations in Msinga

Below, I offer brief background information on the four NGOs providing IPV services in Msinga. The information was shared during the individual interviews and offers an understanding of the organisations' contexts and backgrounds. Three of the NGOs were situated in Msinga and one (LifeLine and Rape Crisis) had their main office in Pietermaritzburg. The latter had a crisis centre at the Church of Scotland Hospital (COSH) in Msinga. The eight interviewees were all employed by the organisations. All spoke isiZulu as their native language, all were of African descent and all came from Msinga. In some instances,

the names of the interviewees were not disclosed to protect their identity as per the ethical considerations of the study.

1. The Khayelisha Care Project offers food security and psychosocial support to orphans and vulnerable children in Msinga, step-down care to children suffering from TB, HIV/AIDS and malnutrition, home-based care to children living with AIDS and foster care for children without placement in the community. It also promotes and empowers community-based projects to offer similar services in their communities. Importantly, the project has a shelter for the women survivors and victims of violence. The project director and a care worker were interviewed.

2. The uMusa woMsinga Project developed from the Novi Bazi Clinic. The Augustinian Sisters, inspired by their love of God and neighbours, had worked at the clinic since 1965. The clinic was closed in 2013 as the services were taken over by the local district health department. Alongside the clinic, other projects were developed over the years in response to the needs of the Msinga people. Two Sisters had come to Msinga and together with the Augustinian Fathers from Nigeria reached out to the surrounding community where Catholics were few and the needs great. One sister worked in the government clinic while others were involved in various projects with the assistance of 40 home-based carers and other volunteers. One of the projects is the uMusa woMsinga Project. It currently receives funding from Homeplan, an organisation in Holland. Services provided by the project include, in the main, psychosocial support through counselling and support groups to the victims of IPV in Msina. It also meets the needs of children suffering as a result of IPV through placement, food parcels and so forth. The project supervisor and a care worker were interviewed.

3. LifeLine Pietermaritzburg was established in 1972 as an independent centre affiliated to LifeLine South Africa. In 1998, LifeLine Pietermaritzburg increased its scope to incorporate programmes addressing the scourge of GBV. It subsequently merged with the Rape Crisis Centre, Pietermaritzburg thereby strengthening its resources for mitigating the effect of GBV. Over the last decade, LifeLine Pietermaritzburg has been developing and employing different community-based models to increase awareness of

GBV with the long-term goal of eradicating institutions, structures and practices that negate human rights, specifically the rights of women and girls. Msinga is one of the areas targeted by Lifeline and Rape Crisis. Based on the services they offer to the women survivors of IPV, one social worker and a social auxiliary worker were interviewed.

4. The Sinozwelo Resource Centre was established in 2001 to promote the safety and wellbeing of orphaned and vulnerable children, especially those coming from families affected by HIV. It also provides psychosocial support to the children. As GBV, especially against women and children began to increase in Msinga, the centre started to shift focus and began supporting victims and survivors of GBV including those experiencing IPV. This organisation is highly dependent on volunteers that are paid stipends. They support the one full-time social worker and two social auxiliary workers in the provision of the organisation's services. A social worker and a care worker were interviewed.

Table 2: NGO staff participants by gender and position held

Organisation	*No. of participants*	*Gender*	*Position held*
Khayelisha Care Project	2	Female	Executive director Community care worker
uMusa woMsinga Project	2	Female	Social worker Social auxillary worker
LifeLine and Rape Crisis	2	Female	GBV project manager Lay counsellor
Sinozwelo Resource Centre	2	Female	Lay counsellor Community care worker
Total	8		

3.8 DATA ANALYSIS

According to Bertram and Christiansen (2014), data analysis is a process that comprises data reduction, deciding which data to include, data display of information, conclusion drawing, findings of the patterns formulated and verifying information. For this study, data were analysed using the inductive approach and thematic analysis. The inductive approach commences with precise observations of raw data and moves to generalisations, patterns and theories (Bertram & Christiansen 2014; McMillan & Schumacher 2010). This approach is convenient for the reason that a qualitative study is more open-ended and exploratory in nature (Bertram & Christiansen 2014) and general conclusions emerge from data rather than theories being imposed (McMillan & Schumacher 2010). Braun and Clark (2006) stated that thematic analysis involves identifying, analysing and reporting themes or patterns within the data. Thematic analysis is valuable because it unravels or unties the surface of reality (Braun and Clark 2006). Thematic analysis was the method used to analyse groupings and present themes that emerged from the data. All the individual interviews and focus group discussions were transcribed and the transcriptions analysed using the open coding technique to identify themes and sub-themes (Creswell 2003:153-155). As noted, the individual interviews and focus group discussions were tape-recorded with permission to do so having been obtained from the participants. In doing the analysis, the three steps recommended by Vithal and Jansen (2002: 27) were followed, namely, scanning and cleaning of data, organising the data, and representing the data. The themes that emerged from data included participants' understanding of the meaning of IPV, its prevalence, the availability and effectiveness of IPV programmes, and their suggestions for further IPV programmes to reduce incidents of IPV in the Msinga area.

Thus, directed by thematic analysis, I examined the IPV survivors' realities, experiences, and meanings they had of the IPV programmes in the Msinga area. The examination was done across a data set derived from focus group discussions and individual interviews to discover repeated patterns of meaning. The process involved familiarising myself with the data by reading and re-reading transcripts, noting ideas, collating data and searching for themes to produce a final report which responded to the research questions and incorporated the relevant literature. Also as noted, the individual interviews and the two focus group discussions were transcribed. The one focus group discussion was transcribed by an expert from IsiZulu into English. I did the remaining transcriptions. This sharing of transcribing was done to reduce my workload and to ensure the fast progress of the study. After the transcribing I then, as

mentioned, read the transcriptions several times to familiarise myself with the content to enable the identification of patterns and the formation of themes.

3.8.1 Trustworthiness

In qualitative research, it is difficult to attain reliability and validity due to the evolving nature of human behaviour and the multifaceted nature of reality. According to Lincoln and Guba (1985), ensuring reliability and validity in qualitative research is through trustworthiness. The authors created four constructs to consider when judging the quality and rigour of qualitative research, namely, credibility, transferability, dependability and confirmability. It is important to establish that the findings of a qualitative study are credible, transferable, confirmable and dependable.

This study demonstrated what actually exists as per Brink (1993). The focus was on the participants' beliefs, lived experiences and meaning systems from their perspectives. The consistency, stability and repeatability of the informants' accounts as well as the investigator's ability to collect and record information accurately, were taken into consideration (Selltiz et al 1976:182). The researcher, when using comparable methods and comparable subjects, should obtain comparable results. The focus group discussions and the interviews using a mix of open and closed questions were used to investigate what was intended by the study. Bickman and Rag (2009) argued that it is critical for the researcher to remember that almost all measures contain some degree of error; the challenge is to minimise the error or understand it sufficiently to adjust the study.

3.8.2 Credibility

Credibility establishes that the phenomenon being studied is represented and recorded in its true sense (Shenton 2004). To ensure credibility in the study I firstly used a combination of individual interviews and focus group discussions to generate data. This was beneficial, as Shenton (2004:65) pointed out, "While focus groups and individual interviews suffer from some common methodological shortcomings since both are interviews of a kind, their distinct characteristics also result in individual strengths." Secondly, with the consent of the participants, I recorded the interviews and group discussions on an audiotape recorder to precisely capture the participants' words. Thirdly, I referred, consulted and employed

debriefing sessions with my supervisor to discuss the study and the courses of action adopted. In this regard, Shenton (2004:67) stated that such meetings "provide a sounding board for the investigator to test his or her developing ideas, interpretations and probing from others which may help the researcher to recognise his or her biases and preferences."

3.8.3 Transferability

Transferability refers to providing adequate detail of the context of the fieldwork conducted to allow for others who come across the research to make comparisons of other contexts with the one provided (Shenton 2004). Ensuring transferability in a qualitative study is not easy and may not be accurate since the findings are specific to the study's context and the individuals being studied. Consequently, Lincoln and Guba (1985) recommended that the researcher includes a full description of the context of the study, to enable the reader to make a transfer. In this study, I provided adequate information about the study context for the readers and other researchers to have a better understanding of the phenomena under investigation and, therefore, to enable them to make comparisons with their own circumstances. Information concerning the limitations of the study was also highlighted because it would be beneficial for the reader and researchers to understand all aspects of the study, including the context, situations, times and populations before making comparisons.

3.8.4 Dependability

Shenton (2004) indicates that dependability is used to demonstrate that the findings are consistent and reliable and there is sufficient information for a future investigator to repeat the study. In this study, in-depth coverage of the research procedures followed was provided, that is, the research design and its implementation, the process of data collection, and a reflective evaluation would enable a future researcher to repeat the study. A voice recorder was used, and field-notes were safely kept to verify that my findings were consistent and repeatable with the raw data I collected.

3.8.5 Self-reflexivity

Gilgun (2008) stated that reflexivity is commonly understood as an awareness of the influence the researcher has on the people or topic being studied, while concurrently recognising how

the research experience is affecting him or her as the researcher. According to Cooper and Rogers (2014), a reflexive position is used to gain deeper engagement and insight into the participants' understanding of lived experience which has always been part of the nature of qualitative research. Furthermore, reflexivity is a process that contains conscious self-reflection on the part of the researcher to make explicit their potential influence on the research process. Giorgi (1986) argued that the researcher always gains access to a field of inquiry with definite ideas of what it is all about. Malterud (2001) found that distinguishing the diverse aspects that influence the relationship between the investigator and the interviewee and how they consequently influence the kind of information gathered is a significant component in their interpretation. This requires "researcher's reflexivity" that is, "the knower's mirror" in probing ways in which researchers and interviewees collectively engender knowledge and interpretation (Finlay 2002; Lofland & Lofland 1995). Through reflexivity, the researcher and the interviewee position and construct themselves in relation to the conversation and its subject, producing related identities (Rapley 2001). Thus, the researcher not only directs the gathering and analysis of research data but is also "part of the co-creation of knowledge."

Reflexivity starts at the point of recognising the assumptions that the researcher brings into the research such as personal and professional experience, pre-study opinions about how things are and what is to be discovered, motivation, qualifications for exploration of the field, and the perspectives and theoretical bases linked to their learning and interests (Kirsti 2001). Finlay and Gouch (2003) established that through reflexivity, qualitative researchers reflect on their bias and how their background, anticipations and behaviour influence the inquiry process including how the study population reacts to the research and the study environment. Reflexivity thus necessitates that researchers regularly reflect on their actions and their responsibilities in the data collection process and analyse how these influences their data (Finlay and Gouch 2003). These issues could be deep-rooted within persons and reflexivity is thus important in providing a better understanding of oneself in qualitative research. According to Pillow (2003), reflexivity is crucial to legitimise, substantiate and question the research process. This simply means that researchers need to constantly use reflexivity throughout the research process to detect any possible influence they may have on the research design, participant selection, the setting and the conduct of data collection, and on data interpretation and presentation.

According to Hesse-Biber and Leavy (2006), there are two types of reflexivity that have a possible influence on the data collected in qualitative research: (i) personal reflexivity and (ii) interpersonal reflexivity. Personal reflexivity is concerned with how the researcher's own contexts and presumptions may influence the research process and data collection (Hesse-Biber & Leavy 2006). Interpersonal reflexivity is concerned with how the interview locale and the interpersonal dynamic between the researcher and the participant influence the knowledge engendered. For example, if a good working relationship is created between the researcher and the participant or if the interview setting is such that the participant feels uncomfortable, then either situation will affect the data that is collected during the exchange. Based on the above-given explanation of self-reflexivity, I made use of both personal and inter-personal reflexivity and this is elaborated on below.

I worked for an NGO called LifeLine and Rape Crisis in Msinga under their GBV section between 2012 and 2015. As a manager, I provided support to the social workers and fieldworkers who were implementing remedial activities for the survivors of GBV. The survivors of IPV would often be hesitant to disclose their situation and would report unfavourable experiences with service providers who failed to detect their challenges or denied their existence. Later, my personal interests drew me to focus on empowering women who were facing the challenges of IPV. My first encounter with GBV took place during a community event at which I led a training session. After the training, women attendees decided to create their own action-orientated dialogue groups facilitated by GBV ambassadors. In these groups, many sad stories on IPV were shared and many cases of IPV began to be attended to. Indeed, the GBV section that I was leading would receive nothing less than an alarming 80 IPV cases a month. It was these experiences that drove me to examine the effectiveness of the strategies employed by the organisations dealing with IPV in Msinga.

My involvement in working with IPV survivors has exposed me to a diverse learning experience that helped me to better understand the field of IPV and subsequently to have a genuine wish to contribute to it. My work experience as a social worker and former GBV project manager has helped me to better understand the concepts I have encountered in this study and see them applied in real-life contexts. It has also helped me to better understand the possible root causes of IPV in Msinga and the reasons why victims and survivors of IPV would endure abuse. Moreover, having the same ethnic background as that of the research participants meant that we shared a common language (IsiZulu) as well as other cultural characteristics.

This added value to the study as I could identify with what they were sharing during the interviews. For example, a common cultural belief in Msinga is that IPV should be treated as a private matter. It is for this reason, as discussed in the literature, that many cases of IPV against women are unreported. It is due to having this background that I requested the interview venue to be private, quiet and physically comfortable. I understood that some of my interviewees were uneasy with being contacted and interviewed at or within the vicinity of their home. They neither wanted the interviews to attract attention nor the subject matter of the interviews to be made public.

As will be shown in the upcoming chapters, some of the women survivors of IPV had never disclosed their violations to their immediate family members (children, parents, siblings and in-laws) for fear of being treated as outcasts and for fear of having their male partners arrested thus leaving them no economic support. With this knowledge, I understood that having interviews at their homes would not have been appropriate for most of the participants. This meant identifying venues that were suitable for all the study participants. Consequently, arrangements were made with the NGOs to have the interviews conducted in their offices where, because of privacy, it would not be easy to identify the kind of discussion taking place.

I also understood that an important principle in Zulu culture is that respect is maintained for everyone. As a result, interviewing women of any age required me to focus on maintaining respect throughout my interactions with them. Furthermore, to prevent a situation where I would encounter undesirable attitudes during interviews, I asked members of staff from the NGOs to introduce the study to the participants on my behalf. These organisations have walked a long journey with the women survivors of IPV and trust had been established. For example, I noticed that the women survivors associated freely with the staff members. Through their introduction and debriefing which they always did before I commenced my interviews, I was able to effortlessly steer and conduct the interviews with women across all age groups. To avoid tension and awkwardness, I established a good rapport with the participants and all the interviews went smoothly. Nonetheless, I did understand that I had to treat each participant individually as no one interview would be the same.

I do acknowledge that the study findings might be affected by authority dynamics which placed me at the forefront as the researcher and interviewer. As a result, participants may have been intimidated and withheld some information. To counter this possibility, I tried my best to treat

all the participants with respect and dignity and provided a welcoming and safe environment. In doing so I do believe that the responses I received from the participants were valid and that information was not intentionally withheld. In this regard, Creswell (1998) has argued that the researcher's determination to minimise his or her distance and separateness to their relationship with the participant is critical. Some traditions, such as the feminist tradition, take it on themselves to bring an end to the oppression of specific populations (Maguire 1987); to vigorously remove the authority imbalance between the researcher and the participant (Brayton 1997); and to remove the notion of ownership of the research from the researcher and to substitute ownership with the participants (Wolf 1996). The intention in terms of my approach to the interviews conducted was to establish a relationship between myself and the participants in which both of us felt significant levels of involvement. As pointed to by Creswell (2014), the researcher's training and experiences also have a bearing on their choice of approach. My interviewing skills based on my social work experience proved useful while conducting both the individual interviews and focus group discussions. Furthermore, my work as a social worker influenced the focus of the study. Finally, my social work qualification and experience in working with IPV survivors gained over the years enabled me to appreciate that the values, opinions and experiences the participants brought to the research were positive contributions.

The benefits of self-reflexivity in this study included accountability, trustworthiness, richness, clarity, ethics, support and the overall integrity of the research process. The quality of the data collected, knowledge generated, the ethical treatment of those being studied, and the participants' and my own (as the researcher) well-being were taken into consideration in the study. While ensuring that the data collected constituted the participants' views (Shenton 2004), my views on the matter were reflected in the discussion of the research findings. Individual interviews and focus group discussions were used as methods of data collection to capture, as far as possible, the participants' responses truthfully and, as alluded to above, my values, perceptions and subjective views were captured in my critiques. To further ensure the validity of the data collected, all the transcripts of the interviews were taken back to the participants for them to verify. There were no problems in this regard. According to Green and Thorogood (2004) and Finlay (2002), researchers need to find a balance between complete reflexivity and becoming too analytical. The authors pointed out that the researcher's position can become excessively privileged, blocking out the participants' voices. As made clear in the discussion above, I tried my utmost to avoid this situation occurring.

3.9 ETHICAL CONSIDERATIONS

Given the qualitative nature of the study, I interacted intensely with the eight NGO members of staff and the 32 IPV survivors entering their personal domains of values, weaknesses, experiences and the like to collect data. According to Silverman (2000:201), researchers need to always remember that while they are doing their research they are, in actual fact, entering the private spaces of their participants. Understandably, this raises several ethical issues that should be taken into consideration both during and after the research has been conducted. Creswell (2003) correctly indicated that the researcher has a responsibility to respect the rights, needs, values and desires of their participants.

The literature presented in Chapter 2 indicated that women and girls living in Msinga are vulnerable to gender and IPV. To have "rich" findings I purposively selected women who were in abusive situations and my sample, therefore, comprised participants who had or were experiencing IPV. Before each interview session, the issue of confidentiality was discussed and assured and the interviewee's consent to participate in the study obtained by their signing of an informed consent form. The participants who may have been exposed to social stigmatisation or secondary victimisation were referred for counselling to the NGOs' social workers and counsellors. In addition, those participants who disclosed sensitive information that they found traumatising were similarly referred for counselling. I also informed the participants not to reveal information they viewed as sensitive if they did not wish to do so. Since I am trained to deal with the issues under study, I was well-positioned to identify possible problems during the interviews and refer the affected participants to the social workers and counsellors for face-to-face counselling. In line with ethical considerations, the participants were reminded at regular intervals that they could withdraw from the study at any time without any negative consequences in doing so.

3.10 FIELDWORK CHALLENGES AND LIMITATIONS

3.10.1 Fieldwork challenges

There were several hurdles that I faced during the research process. To begin with, the pre-arranged venue for the focus group discussions was found to be unavailable on the specified

day. On enquiry, I was told that the venue was only available for 30 minutes and this resulted in the focus group discussions being postponed. New arrangements were made and two different venues (both of which could accommodate the focus groups' participants), namely, the premises of the Khayelisha Care Project and the Sinozwelo Resource Centre were used. Another challenge faced was the lack of time management on the part of the participants. Most of them came to the interview venues at least an hour later than the agreed-upon time. Even though these challenges inconvenienced me, the study, however, was conducted successfully and the challenges had no bearing on the quality of data generated.

3.10.2 Limitations

Limitations exist in all studies and this study was no exception. The study was limited to examining the IPV programmes employed by organisations to address the needs of women in Msinga experiencing IPV. Only organisations which operated in Msinga and which had programmes on IPV prevention were included and a sample of their staff and the women they offer services to subsequently interviewed. The study was an important one as violence against women is still extensive and there is a need for appropriate interventions. Given the small size of the sample and the focus on a rural community (Msinga), there is thus a need to be cautious not to generalise the findings to all IPV programmes employed in South Africa. It is critical that findings are to be understood in terms of the context of the study and not from a universal point of view. Finally, what the participants reveal to the researcher in a focus group is shared with other group participants and this may raise privacy issues (Morgan 2013) which may, in turn, limit the amount of information that participants would be willing to divulge thus impacting on the study as a whole. The study thus also included individual interviews which, being private, facilitated participants sharing information that they would not have had they been in a focus group situation.

3.11 CONCLUSION

This chapter provided the research design and methodology employed in conducting the study. The interpretivist paradigm was discussed as the most appropriate paradigm for the study. The study adopted a qualitative methodology which facilitated an in-depth understanding of the issues being investigated. In this regard, both focus group discussions and individual interviews were used to collect the data. Processes concerning data generation and data analysis were

described. The sampling method, demographic information about the participants, and methods of data analysis used were clarified and justified. The critical issue of trustworthiness of the data collected and its respective benchmarks were presented and discussed. The ethical considerations of the study were outlined as were the challenges experienced during the fieldwork. The chapter ended with a delineation of the limitations of the study.

The following chapters present and discuss the findings of the study. To begin with, the experiences of IPV among women in Msinga are documented.

CHAPTER 4

EXPERIENCES OF INTIMATE PARTNER VIOLENCE AMONG WOMEN IN MSINGA

4.1 INTRODUCTION

As indicated in the preceding chapters, this study investigated the experiences of women survivors of IPV in Msinga and the effectiveness of the programmes being implemented to address their needs. In the preceding chapter, I discussed the methodology adopted to conduct the investigation. This chapter presents and discusses the first of the key research questions of the study, namely, "What are the experiences of women survivors of IPV in Msinga?"

The findings that are presented below arose from the data obtained through in-depth interviews and focus group discussions with women survivors of IPV in Msinga and staff members of NGOs involved in interventions addressing the needs of the women survivors. The themes that are presented stem from the women's direct understandings, interpretations, beliefs, observations of surroundings, and life experiences relating to IPV in Msinga. The chapter starts with a discussion of the socio-cultural context of Msinga which has been found to be one of the main drivers of IPV in the area. The themes that emerged from the analysis of the data are then discussed, namely, the prevalence of IPV, the causes and understanding of IPV, the succession of violence, the types of IPV, the reasons for women staying in abusive relationships and, lastly, the effects of IPV on women in Msinga. The terms interviewees, women and females are used interchangeably to refer to the participants as they (the participants) used them interchangeably when referring to themselves as women survivors of IPV. In contributing to this research, the participants spoke voluntarily and openly of their intimate relationships as well as those of others they had witnessed and heard about while living in Msinga.

4.2 SOCIO-CULTURAL CONTEXT OF MSINGA

By and large, women in Msinga have a convoluted and twisted notion of cultural lifestyle which has accepted and reflects the prevailing patriarchal values. Ntlama (2009) argued that the characterisation of gender equality as irreconcilable with the values and principles of

customary law undermines the very social change objectives that are entrenched in the Constitution. According to Nyasani (1997), Msinga women epitomise the positive traits of traditional cultural lifestyles. While the socio-economic indicators for Msinga are bleak, the area is arguably one of the last repositories of Zulu culture. The people of Msinga are proud of and satisfied with their heritage and this provides them with a strong sense of identity (Motlafi 2017). Nevertheless, the institutions underpinning their cultural heritage and practices are in some instances in conflict with constitutional principles of individual rights. These instances include:

- Homesteads being headed by male partners who might have more than one wife.
- The payment of the bridewealth (lobola) serving to formalise the handover of the women's reproductive rights to her husband's family.
- Wedded couples and their children having to endure living in their parents' homesteads for many years before starting their own. This increases the size of homesteads which now accommodate multiple generations and married couples. The family unit, as the most basic unit of social organisation, is consequently perceived as an "extended family" of close patrilineally-linked relatives and not a "nuclear" family of a man and his wife or wives and their children (Motlafi 2017).

Nyasani (1997) spoke of hospitality, friendliness, harmony and the common framework-seeking principle ubuntu, with its emphasis on community rather than the individual, as being highly practised in the Msinga area. However, society and culture also make it problematic for women to assert their rights. At one level, provision is made in the Constitution for promoting the protection of women's rights and the attainment of equality (Siqwana-Ndulo 2013). Simultaneously, the Constitution endorses the right of customary authorities to apply customary law (Siqwana-Ndudo 2013) which, in effect, makes provision for a parallel justice system that imbeds customary practices that largely discriminate against women. This is further entrenched by local government's implicit support for customary practices, such as offering funding for maidens from the Msinga area to attend the annual Umkhosi Womhlanga or Royal Reed Festival at King Zwelithini's Palace in Nongoma (Motlafi 2017).

The scarce livelihood opportunities (particularly given the low levels of education) the ancient communal conflict, customary values and contradictory legislation make women and young

girls in the Msinga area more vulnerable to being victimised and their rights being violated. The situation thus attracts attention to the issue of gender relations, the abjective conditions of the women of Msinga, and the difficult task NGOs have set themselves in their IPV interventions. Msinga is a grossly underdeveloped area with poor infrastructure (most severely evidenced in the community's difficulty in accessing water), high levels of unemployment and low levels of economic activity and education (Gibbens & Schoeman 2020). Additionally, it is a rural community where people live in thatched huts with mud walls and conform to local tribal rules (primarily Zulu).

While South African law endorses that women should be given equal access to their rights as human beings, this is not often socially practised and possibly obstructed through broader social discourses, structures and processes which still tend to favour patriarchy. This is undoubtedly the case in Msinga where, according to Zulu tradition (and in line with "living" customary law), a man must pay lobola (bridal price) to the father of the women he is marrying. After that, the woman will move to her new husband's household and be allocated land (which is not hers to own but to utilise while she is part of the family) on which to raise her children. This will simply mean that a woman owns nothing in the household. The man will treat her as part of what he owns and she will not have a say in the household.

In Zulu culture (and in Msinga more specifically) the principle of primogeniture is practised, (Rautenbach et al 2006). This practice means that only males can be heirs and inherit property. Maluleke (2012) argued that primogeniture is not an original African practice but was imposed by colonialists and retained by males because they benefited from it as they were able to monopolise property ownership. The reason for this is because customary law treats women as minors in that they are under the guardianship of a male figure (initially the woman's father and later, the woman's husband) who retains control of all assets (Beninger & Williams 2010) thus providing men with the power to have control over women. This state of affairs also accounts for the fact that women face significant challenges in successfully fighting IPV in Msinga.

Given the above, it evident that women's movement and their ability to secure decent provisions are mostly dependent on the men in their lives (whether it be father, husband, brother-in-law or son) and that women are far removed from the discourse. Therefore, even though traditional practices may be shifting in terms of how marriages are entered into, this

does not necessarily mean that traditional patriarchal structures that mostly perpetuate violence in Msinga are being challenged. Rather, they are dynamic and fluid and are still able to uphold control over women and their well-being through social practices which favour the rights and powers of men. The strong traditional culture prevalent in Msinga is a positive attribute that is being preserved and valued it is, however, discriminatory to women. Thus, it is unlikely that women from traditional backgrounds will have the support of their traditional leadership in combatting issues of IPV. According to the Msinga authorities, the traditional leaders, apart from providing support mechanisms for the communities, are also custodians of the culture (Lottering et al 2020).

Historically, under apartheid laws, black South Africans (particularly women) have been compromised in terms of education, access to healthcare and earning capacity. This is still currently the case as reflected in the 2008/2009 South African Living Conditions of Household Survey (LCS). The survey revealed that 25% of black households fell within the lowest quintile of annual household consumption expenditure compared to 0.7% of white households, whereas 81% of white households fell within the highest quintile compared to 8.2% of black households. Furthermore, the differences in obesity and disease prevalence between these ethnic groups may be partly attributed to or mediated by these social inequalities. Puoane and Mciza (2009) confirmed that black South African households, as discussed above, are intensely patriarchal with men holding a dominant position. For this reason, boys have been better cared for and nourished as babies and infants and thus do not necessarily experience the same level of nutritional deficiency at a young age as girls (Puoane & Mciza 2009). It is apparent that these gender imbalances are nurtured at a very young age and a boy child would grow up believing that he is superior to a girl child.

A post-structural feminist lens is predominantly concerned with exploring the relationships amongst "discourse, gendered identities, power relations and organizing" (Ashcraft & Mumby 2004:108) and one of its foremost contributions lies in rethinking how knowledge is built and reproduced and to whose advantage (Calás & Smircich 2014). A focal area for critical feminist scholars has been to show the favouring of masculinist behaviours in leadership theorising and the supremacy of cultural masculinism in studies of organisational culture. Different critical studies have discovered how hegemonic masculinity offers the organising logic for patriarchy and consequently privileges men in both the public and private realm (Collinson & Hearn 1994; Connell 1998; Hearn 2004; Hearn & Collinson 2018; Messner 1997). This rationality is

premised on uneven power relations between men and women, and also those men who do not conform to idealised philosophies of hegemonic masculinity. It was revealed during the interviews that some women in Msinga find themselves vulnerable to IPV because of the domination of men endorsed by unequal power relations and discourse. In Msinga, men are given more power which in turn leads to the marginalisation and oppression of women. This was confirmed by two of the women participants:

> "*If your man tells his partner to jump, the partner is not expected to ask any other question except to ask how high.*" – Cici.

> "*…even our mothers and grannies taught us to give respect to our men as they are our earthly gods and that was what they were practising too. A woman with dignity cannot argue with a man especially if your man had shown you some respect by paying lobola.*" – Zothile.

Furthermore, the post-structural feminist theory argues that women in disadvantaged communities with no access to services to meet their basic needs are more vulnerable to oppression in the household, community and society than those from other contexts. IPV thus unfolds in a specific context in which layers of disadvantage keep women in a deprivation trap, leading to a brutal cycle of poverty. This observation emphasises that women's everyday realities are context-specific. It is against this background that Oyewumi (2002) stated that feminist theory cannot be restricted to gender oppression while overlooking racial and class oppression since women do not share communal problems. Therefore, the post-structural feminist theory maintains that women are not a homogenous group as they experience oppression in different ways. The findings of this study revealed that IPV is prevalent in Msinga and that the majority of the women participants in the study experienced multiple forms of IPV.

4.3 PREVALENCE OF INTIMATE PARTNER VIOLENCE IN MSINGA

It is noted that the prevalence of IPV continues to increase at an alarming rate, affecting typically women and girls globally (WHO 2013). For instance, according to the WHO (2013), the incidence of IPV against women stands at 30% globally. Research on IPV has gained in popularity and is a significant area for gender studies research, policy, education and practice.

South Africa is one of the nations with the highest rates of IPV globally, despite the legal entities and intervention programmes in place to deal with the problem. Both research and anecdotal evidence suggest that violence against women in South Africa has extended to epidemic proportions. Allsworth et al (2009) argued that about 25% of women have experienced some type of physical, sexual or emotional violence in their lifetime, and approximately two-thirds of this violence is perpetrated by current or former partners. Violence in the home is not a new phenomenon and has always been part of human experience (Krug et al 2002) and was recognised as far back as the Roman Empire (Eddleson 1999). Many South African women experience violence within their households. The interviews held at Msinga suggest that there is still a high prevalence of IPV and not enough is being done in the area to prevent or tackle it. The literature suggests that even though IPV affects all societies across racial and class boundaries, women from deprived socio-economic backgrounds are disproportionally affected. Chambers (2014) argued that the poor are those who are powerless to make decisions due to physical weakness, isolation and limited access to finances, skills and knowledge. As previously noted, in the apartheid era, government policies engineered poverty to affect more Black people than other racial groups. Black South Africans worked as labourers for low wages to provide for their families while generating wealth for the White minority (Coovadia et al 2009). Like most other countries globally, South Africa still contends with women's subordination in society, which leaves them vulnerable to various forms of abuse. The available literature claims that even though policy and legislative frameworks exist to eradicate IPV in both the private and public spheres, women continue to face abuse in their private lives.

LifeLine Pietermaritzburg made their 2011/2012 GBV cases available and they provide evidence that there is a high prevalence of GBV, including cases of IPV, in Msinga. During that period, LifeLine Pietermaritzburg had seen 2 080 new cases of GBV and among these were IPV cases (Biyela 2014). This is also confirmed by Katongole-Mbiddle et al (2009) who pointed out that the Lifeline and Rape Crisis Centre in Pietermaritzburg received at least 100 rape victims for personalised care and support each month. This only talks to a single form of IPV. These were not merely figures but were actual people with real emotions. Other NGOs also confirmed that there are a high number of IPV incidences in Msinga. The Khayelisha Care Project revealed that they receive nothing less than 85 new cases of IPV a month and mostly it would be women between the ages of 18 and 35 years.

"*After 2013 when we started sensitising Msinga women in particular with issues of IPV, we started to note a drastically increasing number of IPV cases being reported to us but I do not want to lie some people still believe that IPV is a private matter hence they do not come forth.*" – Du from LifeLine and Rape Crisis.

"*We even go short of beds in our shelter in some months as they are many women needing our services*." – Thembelihle from the Khayelisha Care Project.

Women survivors of IPV also pointed to the high prevalence of IPV in Msinga. An alarming development is that the women survivors of IPV have lost faith in the police being able to protect them. They perceive the police officers as corrupt, inept and uncaring. Furthermore, the police stations in Msinga are in a poor state, best described by the NGOs as under-resourced and under-staffed with existing staff being inadequately trained to deal with issues of IPV. This will be further explained in the chapters that follow. Below are the voices of the women participants illustrating the high levels of IPV in Msinga:

"*The level of IPV in Msinga is very high. 9 out 10 women are experiencing abuse in Msinga*." – Nomalanga.

"*I would say close to 90% of women here in Msinga are abused by their partners, therefore the level of IPV is very high in Msinga. It has become a norm for women to be abused physically, verbally and emotionally by their partners*." – Londiwe.

"*The level of IPV in Msinga is very high, it's just people who are abused are afraid to speak out. In Msinga IPV has become a norm.*" – Duduzile.

"*It is really hard to tell the ratio and the level of abuse here around Msinga since many people still think that talking about these things is a taboo and besides most of these things happen behind the closed door but I can assure you that the level is too high.*" – Lindiwe.

"*Msinga as a deeply rural area that it is the ratio of the abuse is very high maybe 88% of woman in intimate relationships are being violated, some of them without even being aware that they are being abused*." – Zamile.

"*From what I have heard and observed around our valley, it is very common that a woman will be abused by her partner. Men here demand respect, they will tell you they are Zulu and they will not tolerate being back-chatted. A most common one is those men that drink all day and come back home and display violent behaviour. We have had many of those instances. Men are unemployed, they get frustrated and take it out on us women because we are easy targets, men at the drinking places hit back, women have no way to defend themselves. So, I would say the level is quite high*." – Thobekile.

"*IPV is such a sensitive topic, it is not easy to know when it's happening to others around you because people keep it a secret. You don't go around telling people that your husband or partner beats you, they will ask you what you did and assume that you are unfaithful and sleeping around. I know of a few women who get beaten by their husbands only because family members will talk. Other than that, it's a family secret when men are abusive*." – Cici.

"*Msinga is a large area with many scattered villages it will be difficult for me to quantify the prevalence of IPV for the area but from what you see and hear around there is a lot of women bashing going on. Men here think they own us; we have no voice because we are women. They can have many partners we must stick to one. They can smoke and drink, we are seen as unpleasant and uncultured when we drink and smoke. A man becomes like your baby. You must cook for him, wash for him and also avail your body to him – that is already abusing before the hitting has even begun*." – Nonhlanhla.

IPV is a major challenge that affects everybody (Slabbert 2017) and is a violation of human rights globally (Mengo 2016; WHO 2013) including South Africa (Davhana-Maselesele et al 2009). It is associated with undesirable consequences for victims and survivors' physical, mental and social well-being (Bernstein et al 2016). The effect of IPV is far-reaching, with serious outcomes not only for the abused woman but also for her children and society at large (Slabbert 2014). The research participants in this study were exposed to various forms of IPV including physical, emotional, sexual and financial abuse. I would like to believe that it is most women's wish or dream to get married someday and when things are not going well in their

marriages, they take time to make a sound decision regarding their future as they would not want to see their dreams fading away. A participant's story was as follows:

> "… *marriage is regarded as the greatest achievement in this community. My husband was very abusive to me after we got married. I am a housewife as we all know that in the rural areas when you are a wife you have duties to do at home. He used to do everything at home like groceries including my cosmetics. My husband started drinking and he will just disappear without informing me. He even started being rude towards me, he will say I am useless I can't even work and buy myself cosmetics. It was early in the morning when women and a pregnant girl came into my house. I was busy with the house chores as a housewife. When I saw these women, I was so confused about what was happening. They mentioned that they have come to report that my husband has impregnated the young girl. I couldn't even look at them in their eyes I was so shocked and frustrated at the same time, how can my husband do this. Remember we have two children a boy and a girl. I asked them to leave before I do something I will regret. I was very angry at that time. My husband came back later on and I told him about the pregnant girl. He wasn't even apologetic concerning that and just told me that I am the one who will raise that child. I couldn't believe my ears. Our mothers were socialised to endure every difficulty the marriage comes with and they also cascaded their learnings to us*." – Thobekile.

It is sad to see some women giving up on their children. Children do make mistakes and that is how they grow. They are dependent on their parents to guide and protect them.

A second participant stated the following:

> "'*Stop whining and clean yourself up', that's what my mother said after finding me in bed with SM. What kind of a mother is she? Caring about what will people say rather than the well-being of her own child. I am 23 years old, when I was 15years old I had my 1st boyfriend, he was 19 years old, yes, a bit older than me. One day he asked me to visit him at his house, being young and naïve I trusted him. When we were in his bedroom, he asked me if I loved him, I replied, yes. He then took off my clothes and had sex with me, without my consent. I tried telling him that I wasn't ready but he was too much into it and he did not stop. That was the most painful experience. Right after he*

finished his mother and my mother walked in, I guess they saw us entering the yard. My mother was so ashamed of me, I tried reciting to her what really happened but she couldn't and wouldn't listen. 'Yeh mntanandini, you are the one that told this boy that you love him, so why are you crying now?' And just like that, she sold me to the wolves. Her and Siyanda's mother warned me not to breathe a word about what happened as that will put both our families into shame. My mother also warned me that I should never tell my father about this as he will divorce her, so I did not want to be the reason for my parent's separation. I then kept this secret and let it eat me up inside." – Zamile.

4.4 CAUSES AND UNDERSTANDING OF IPV IN MSINGA

It is critical to comprehend some of the risk factors or causes of IPV against women to understand how more effective prevention and intervention programmes can be established. Having heard the voices of the 32 women survivors of IPV, we can begin to analyse the 12 key themes that characterise IPV for them. The socio-ecological model used in the study shows that violence is a consequence of factors functioning at four interrelated levels, namely, individual, relationship, community and societal (Sitaker 2007). The key themes are described and discussed below.

4.4.1 Violence demonstrates love

According to the WHO (2012), the process of coming to terms with experiencing IPV contains periods of denial, self-blame, long-suffering and trying to relate their circumstances with other women in similar situations. Participants in the women survivors' focus group discussion highlighted that exerting control over women through violence was understood as an expression of love in a relationship.

"*But I sometimes feel bad if my partner decides to say nothing if I have done something wrong, it feels like he does not like me anymore*…." – Cici.

"C*an you just imagine being in love with somebody who does not care; they must show jealousy for you to see that you are still loved and appreciated*." – Duduzile.

"*Things we do at times, really need to some form of discipline, like giving out with your cell phone number knowing exactly that you are living with your man*…." – Khanyisile.

According to the participants, most women endure and put themselves at risk of IPV because violence equates to love. According to Jewkes et al (2010), oftentimes forced sex by an intimate partner is not perceived as rape due to the high stigmatisation of the matter. Subsequently, women cannot refuse sex which is forced by an intimate partner. In his study, Cadena (2011) found that 70% of women had forced sex with their partners for fear of the consequences if they refused to have sex. Likewise, Vetten (2014) suggested that men who rape normalise it and perceive it as a sexual entitlement and a benefit of being in love.

4.4.2 Lobola and women as property

Lobola is part of the Zulu culture and spoken language. It is bridewealth where cattle but nowadays mostly money and other gifts are given for the bride. Broadly speaking, lobola is the whole cultural process that comprises discussion, exchange and transition. Mazibuko (2016) stated that lobola is a cultural practice whereby the groom's family pay money or transfer livestock to the bride's family to gain permission for the marriage. Chireshe & Chireshe (2010) further mention that lobola serves to compensate the bride's family for the expenses associated with raising a girl. Furthermore, it acknowledges the transfer of the bride's reproductive capacity to her husband's family (Rudwick & Posel 2015). In most African communities, the husband's family is expected to pay a bride price (lobola) as compensation to the bride's parents for losing their daughter (Van Der Hoven 2001). Historically, lobola was paid in cattle but nowadays, as mentioned, it is habitually paid in cash and some women's families ask for large amounts of money and expensive gadgets (Reddi 2007). This alone can result in women being abused in their husbands' homes because they are viewed as possessions that were purchased (Reddi 2007). Globally, 1.5 million girls still marry at the age of 15 (Deuba et al 2016).

Thus, marriage in Zulu culture is characterised by the lobola system in which a man transfers some designated possessions such as cattle and money to his wife's family to show respect and create a new relationship. Lobola, however, is seen as a source of IPV in the sense that men take it as a licence to abuse. This was confirmed by four of the participants in the interviews.

As their partners pay lobola, they (the wives) are seen as the property and not the equal of their partners. If women want to be freed from being seen as property, this customary belief has to be dismantled and this can only be done by educating women and men together. It was confirmed by almost all the participants that lobola contributes to IPV against women. Participants indicated that a man will do as he pleases even threatening to kill the woman. Violence is also perceived as normal because a woman is seen as stupid and as someone who fails to behave according to society's expectations. If she does not approve of being beaten, she should make sure that she avoids that by not upsetting the man. Violence is also perceived as normal because a man is regarded as the clever one, as being always right and knowing what he is doing. Furthermore, when a woman "... dares to retaliate with the violence she is treated as mentally abnormal" (Gnanadason 1996:8). A participant remarked:

> "*If you are paid lobola, you should show respect all the times, regardless of the circumstance. A normal woman and well-grounded one would conform all the times as our parents taught us, otherwise you would be a disgrace both in your own family and in your family-in-law. To me, for the fact that I was chosen from the crowd showed that I could bear any challenges marriage comes with. Who said marriage would be easy*?" – Zothile.

It is correct that the practice of lobola has implications for IPV through placing women in positions of subordination to their husbands (Sibanda 2011) and this was confirmed by the research participants. Some participants endured abuse because escaping IPV through a divorce is particularly difficult in this context. Cultural norms, for example, oblige both families to consent to the divorce so that the lobola can be returned to the groom's family (Sibanda 2011). The bride's family may desist from intervening when their daughter is experiencing violence because they cannot afford to return the lobola if the marriage were to be dissolved (Sibanda 2011; Chireshe & Chireshe 2010 and Zondi 2007). Thus, most young women in Msinga would choose to stay in abusive marriages rather than to disobey their parents by pursuing a divorce. Their situation is exacerbated by the fact that they have limited options in terms of professional support structures that can assist them in escaping violence and abuse (Vetten 2005).

> "*He paid eleven cows just for me. I am not working and he does everything for me as he does for our children so he has the full right to discipline me now and then to remind me of my place. And besides, I am like his older child*." – Hleziphi.

The above response from a participant shows that some women allowed their male partners to use the bridewealth (lobola) they paid as a reason for resorting to IPV. It also suggests that women understand that the frustrations of their male partners can lead them to resort to IPV. Some of the participants used gender socialisation of their male partners to explain the origins of violence perpetrated against women. The women participants also used their foremothers as their references as they had also endured such violence since time immemorial. These explanations used in communities where tradition is highly regarded and practised hinder progress made in combating IPV.

Wood (2001) stated that gendered violence is practised and socially permitted around the world. The epidemic of IPV reflects cultural values that are communicated through social practices and structures. It was apparent that some of the women participants perceived lobola as just and responsible and described it variously as a stabilising factor, a significant gift, and an acknowledgement of a priceless debt which the groom's family group owes the bride's family group. There was evidence in some participant's responses of an element of intergenerational transmission of violent behavioural strategies as in the exercise of power and authority that is given to men. One participant's response reflected the dimension of intergenerational violent tendencies:

> "*When I go to my maternal grandmother to complain about the beatings I get from Zaba, she says her husband was and is still no different as he still beats her. My grandmother says there is nothing to do once 'lobola' are paid*." – Kholiwe.

During both individual interviews and focus group discussions the participants referred to the uneven relations between women and men which are worsened by the payment of lobola. It is argued that the traditional and cultural practice of paying lobola continues to impact harmfully on women's socio-cultural equality with men. They feel that they deserve being reprimanded by their husbands.

> "*He has all the right to discipline me because he paid lobola to my family and that alone was showing the love and respect he has for me*." – Khathazile.

From the above statement, it shows that some communities still believe that once a man pays lobola to his in-laws, he has all the right over his partner. Hanner et al (2000) pointed out in their study that a man cannot be condemned for raping his wife and Goldfarb (2007) also confirmed this statement by stating that once women are wedded, they are regarded as one with their male partners which make their issues private. A woman thus loses her separate legal existence once married (Goldfarb 2007). As a result, a case of IPV is regarded as a waste of the public's money and time (Mills 2008) since what happens in the household is considered a private matter (Moser 1993).

Arguably, IPV against women has always been a severe problem and the distortions of apartheid merely rendered such violence either a private issue or one confined to black residential areas and, therefore, of no concern to the police (Fedler 1995).

4.4.3 Lack of support from law enforces

During the interviews, it was found that in most families the couple was, in theory, expected to resolve their problems. The findings also revealed that when married women reported their abuse to the law enforcers, they were told that conflict was normal in marriage and they should go back home and try to resolve their issues with their husbands (Klomegah 2008) without involving external people. On some occasions when married women reported their partners at a police station, the police would escort them back to their home and informally mediate. The husband would be calmed down to enable him to talk things over with his wife (Goldfarb 2007). However, this could put a wife in danger of being abused again as outside people had been involved in the couple's private matters and the husband could take exception to this. Krieker (2001:240) observed that "IPV has a curtain of privacy to shield husbands who beat their wives from the public view and that the parties should resolve their differences in private."

> *"I tried at one stage to report my problem to my nearest police station but they took me back home with their van and spoke with my partner. But weeks after, he started afresh with his abusive traits".* - Ntombizonke.

The study conducted by Stone and Lopes (2018) revealed that KZN has the highest number of police stations that are incapable of rendering effective assistance to victims of IPV. There was a significant number of stations where telephone calls went unanswered, connections were

inaudible, phone numbers were invalid, or the line remained engaged after several attempts at calling (Stone & Lopes 2018). Several police stations in the province appeared to follow a similar trend concerning the provision of false/legally incorrect information or where access to shelter services was conditional on a victim's willingness to press charges or file a protection order application (Stone & Lopes 2018). During the interviews, it was learnt that some cases of IPV would not be legally pursued by going to court because this would eliminate the peace and harmony of the home and that the prosecutor could not base his decision (whether to prosecute or not) on the few stitches the woman needed for her wound. The participants further stated that if enduring "damage" was suffered by the woman, the man would be counselled to go for rehabilitation. Therefore, law enforcers have often allowed women abuse, for the reason that anyone who tries to intervene or reveal the abuse is considered as intruding in normal family life (Silva et al 2015).

4.4.4 Gender roles and intimate partner violence

Almost all the participants were of the opinion that women were more likely to be victims of IPV than men and this corresponded with the evidence from the literature. Although there may be cases where women perpetrate violence on their partners, women experience more violence in their relationships than men (Westbrook 2009; WHO 2002 and Tjaden & Thoennes 1999). According to a participant:

> "*Here in Msinga, most people who have died or went to the hospital due to violence are mostly women. I have never heard of a man committing suicide. I can say with confidence that women suffer the most because they surrender their lives to their boyfriends and want to be the talk of the village and so suffer in private when things go bad as they do not want people to see their difficulties*." – Zamile

Zamile initially blamed women for being battered due to being too involved in their partners' lives. She then blamed male partners for seeing women as objects. For her, it was a two-way street. However, it is women who ended up being battered. Below are some quotes drawn from the individual interviews which provide the women's perspectives regarding the perpetrators of violence:

> "*It is well known that men are physically stronger than women*." – Thobekile

"men are given more power than us women. They overrule us and even our leaders support that so who are we to change the rules". – Zothile.

The primary argument of the post-structural feminist theory is that IPV is rooted in a patriarchal system that condones men's domination and control over women (Larsen 2016). This argument was supported by the responses of the participants in the study. It was revealed during the interviews that IPV typically happens either directly through social and tainted cultural norms of deference and submission supported by traditional authorities, and sometimes by the use of coercion or indirectly by shaping women's opportunities and constraints in basic institutions such as family and work that reinforce women's subordination (Rodriguez-Menes & Safranoff 2012). The recent research has found that the courts are still heavily skewed towards men being the majority members and that is due to the fact that women in these communities do not want to join these courts even when they are asked to do so. Recent research has found that this is because of many reasons; women feel intimidated by being members, women feel theya intellectual inferior to men in these courts, women could be coerced to not become members and they sometimes feel they do not belong to be there. The post-structural feminist theory states that social context is significant in understanding IPV. Notwithstanding the theory being used to explain IPV, it has been criticised for looking only at social gender inequality as a risk factor for IPV. Hence the adoption of the socio-ecological model, which helped me in informing the interactions between the environment and the individual and also showed the processes in human development that could influence men to be violent. The theoretical framework adopted for this study portrayed IPV as a complex phenomenon that required a multidimensional approach and that it should be understood as occurring due to an interaction of multiple factors, ranging from intrapersonal, individual and family to community and society.

"*Men from this village tend to abuse their women more because they have this mentality that a man will always be a man, nothing can change that and that is how they were also raised. It is a society thing, we cannot change. Remember, changing a person's mindset is not going to happen overnight*." – Zothile

"*I have never heard of a well-grounded woman hitting a man in this community. It is always men ill-treating women. But then also seeing a man beaten up by a woman*

would not sound right. If your man is that physically weak who would then protect your family…[laughing]." – Bongiwe.

"*Men are also showed or groomed that a woman is straightened up by a whipping*." – Nonhlanhla.

Most women participants acknowledged that the way men act in their heterosexual relationships was due to their prior learning or socialisation and which was not necessarily about how to conduct themselves "appropriately" in relationships with females. The conception "a man is a man" was extensively used by the participants and thus something they commonly knew about. It pointed to the women comprehending that the "meaning" of men is associated with undisputable dominance.

According to Santana, Raj, Decker, La Marche and Silverman (2006), traditional gender role ideologies include perceptions of how men and women are supposed to think and behave in society and within the context of heterosexual relationships. Gender roles are communicated from a very young age in South Africa and support male supremacy and female subordination, making young women more prone to victimisation (Barkhuizen 2013). Connel (2005) stated that the issue of masculinity does not suddenly appear in the stage of adulthood, but begins at birth through gender role socialisation. This is comparable to findings from previous studies. For example, Barkhuizen's (2013) study of female university students found that men were positioned as authoritative, powerful and dominant over women; while women were viewed as submissive and controllable for the sake of maintaining love and fulfilling men's sexual needs in the relationship. Likewise, Jewkes (2002) claimed that pressures to conform to expected, patriarchal gender roles in relationships exist, and any transgressions of these norms may result in the infliction of violence and the victimisation of women. The findings considered men as perpetrators and women as victims due to socialisation and cultural norms being perceived as fixed and inevitable forces. Flood (2007) argued that the key factor in men's use of violence on women is determined by their antagonistic sexist beliefs, attitudes about gender roles and patriarchy.

The WHO and the London School of Hygiene & Tropical Medicine (LSHTM) (2010) provided examples of norms and beliefs that endorse violence against women:

- A man has all the right to assert power over a woman and is considered socially superior.
- A man has all the right to physically reprimand a woman for "incorrect" behaviour.
- Physical violence is an acceptable way to resolve conflict in a relationship.
- Sexual intercourse is a man's right in a marriage where lobola has been paid.
- A woman should endure violence to keep her family together.

Heise (2015) also confirmed that data from a wide range of countries demonstrate that wife-beating is normative in many settings, with men as well as women expressing support for partner violence under certain circumstances. The lack of knowledge about women's rights and support services for survivors deter women in Msinga from making decisions or accessing resources to escape abusive marriages (Rasool 2015). The lack of awareness of IPV on the part of some women in Msinga makes it difficult for them to easily identify their situation as one of abuse, particularly because it is the norm for men to dominate their wives. According to Rasool (2015), social norms that emphasise family and marriage keep women in abusive conditions. Some families feel the need for and importance of having males as the heads of their families, even if circumstances are not ideal. It reinforces family unity and the dominance of the husband and father even in the face of abuse (Johnson 2001; Edelson et al 2007; Rasool 2015). It also plays an important role in keeping women in Msinga in abusive relationships for the sake of having a husband or a father as the head of the family.

4.4.5 Materialism and "sugar daddies"

Most of the women survivors of IPV I engaged with came from underprivileged backgrounds and relied extensively on social grants. When they reached adulthood, they usually wanted to have an intimate relationship to boost their egos and prove that they were real women. For them to do so, they wanted to look attractive but most could not afford the lifestyle associated with doing so. They then either learnt to accept their circumstances and who they were or found some means of getting those material things that would make them feel attractive and loved. During the individual interviews and in the focus group discussion, the women survivors of IPV articulated that having material things was a necessity at their stage and their partners, at least those who were employed, should be the primary providers of those things.

It is evident that most women who engage in transactional sex are more prone to experience IPV and are at higher risk of contracting HIV. Nevertheless, women engage in transactional sex for a variety of reasons and some of these reasons were evident in the responses of the women survivors. The relationship between IPV and transactional sex is a complex one. Stoebenau et al (2016) argued that women's economic dependence on their male partners may make exiting a violent or exploitative relationship more difficult. However, in Msinga the male provider role is both normative within heterosexual sexual and romantic relationships and an expected means of enacting hegemonic masculinity, the most culturally powerful way of being a man (Brinig 1990; Connell 1987; Glyde 2016; Wentzell 2014). Hegemonic masculinity is habitually asserted and defended through GBV. Jewkes et al (2012) discovered that in South Africa men who endorsed the male provider role within their sexual and romantic relationships were more likely to report perpetrating sexual and physical GBV, had less gender-equitable attitudes, and reported more violent behaviour in general. Women would find themselves having no option but to remain in these unhealthy relationships. Below are some of the voices of participants confirming that poverty can force a woman to remain in a toxic relationship:

> "*I want to further my studies and the only way to do that is to tolerate my fiancé's abusive traits. He is at least employed as a taxi driver. Money is not a problem with him.*" – *Khanyisile.*

> "*My parents disowned me the time they found out that I was pregnant. I had nothing and I needed somebody to take care of me. I am a woman I have got needs like any other women. I am stuck in this toxic relationship only because I have no means to survive without it. I need food, cosmetics, clothes, you name it, so if I leave, will these organisations take care of me?*" – Thokozani.

A woman such as Thokozani sticks to her abusive boyfriend as he is the one supporting her and her children financially. In line with the "sugar daddies" scenario outlined above, it was found that some women, particularly younger women, engage in sexual relationships and end up cohabiting with older men who are their primary source of income.

> "*My parents passed on and I found myself being forced to date a very old man who was going to be able to support me and my family financially and somebody who was going to play a role of a father figure in my life*." – Zinhle.

These men or partners afford the women most necessities and also when needed, take care of their families. However, they often expect submission in return. In such situations, women frequently find themselves being forced to tolerate abuse as not doing so would jeopardise their being taken care of. A participant in the focus group discussion comprising staff members of the NGOs pointed to the extent to which this is occurring (a point agreed on by a majority of the participants in the group):

> "*This is not only happening with the grown women but also young girls have boyfriends named ministers: that is, ministers of finance, ministers of transport, etc*." – FGD#1.

The partner with economic resources frequently dominates a relationship (Dunkle et al 2004). This causes what Adams et al (2012) refer to as authority inequality. It is for this reason that women find it difficult to leave an abusive relationship (Kim & Gray 2008). To ensure their dominance, Mills (2008) points to the situation where the partners of some women that work take their paycheques and some men cause their female partners to lose their jobs by harassing them at work or abusing them so that they have to stay away from work (Adams et al 2008). The main intention of the male partner is to make women fully dependent on them. In this regard, Hoffman et al (2006) added that the abusive partners of unemployed women refuse to permit them to attend job interviews, turn off alarm clocks on the day of the interview, refuse to give them transport money or a lift, stop them furthering their education and confiscate their car keys. Men can also stop women from obtaining assets as well as put them in huge debt and then refuse to pay off the debt, thereby destroying the women's creditworthiness (Adams et al. 2008; Mills 2008).

It is apparent that a woman with a job is more likely to leave an abusive relationship (Hattery 2009). However, in circumstances where they do not have economic resources, women stay in the relationship because they have no other means of surviving on their own (Kim & Gray 2008). Griffing et al (2002) noted that many women that do leave a relationship return because they have run out of money. Other women are found to exchange sex for housing and money (Jewkes et al 2010). Furthermore, condom use is less likely in such relationships as the man holds superior power (Townsend et al 2011). Dunkle et al (2006) claimed that a lack of resources diminishes a woman's ability to practice safe sex, and to decide when to have sex and with whom (Jewkes et al 2010). They are frightened to ask their partners to use condoms

simply because such use is related to promiscuity and disease (Do & Fu 2011). Women do not wish their male partners to ever think that they are immoral and they do not want them (the male partners) to know that they do not trust them (Purdie et al 2010). Women are also scared that if they do not agree to the man's terms, the relationship will end. By conforming with his wishes shows their commitment to the relationship (Stockman et al 2013; Epperson et al 2009). It is concluded that in such relationships, there is no communication around sex (Robertson & Mrachever 2006).

4.4.6 Forced cohabiting and training as wives

Most of the women interviewed confirmed that in Msinga once a girl falls pregnant her family will force her to go live with the boyfriend's family until such time the boyfriend pays for the damages caused. If that is not done, the girl gets disowned by her own family. In light of this, many interviewed participants were cohabiting with their partners. The couples lived together without any form of legal ties (Schmidt 2012). It was revealed in both individual interviews and focus group discussions that in such living arrangements women got trained to be future wives and they found themselves having no say in these arrangements. All they could do was to conform with whatever their men were demanding as they had no other alternative with regard to having a place to stay. During this period, they would be forced to be trained as wives in preparation for one day getting married to the men they lived with. A study conducted at a Nigerian university confirmed that cohabitation is nowadays seen as a preparation for marriage (Arisukwu 2013). The discussion under this theme is strongly associated with that of gender roles and IPV. Men and women live together assuming the roles of husband and wife, whereby the woman is obliged to do house chores such as cooking, cleaning and washing.

> "*I am a wife to be so I need to behave like one before this one sees other women. Tjooo, I can't afford to leave after so much sacrifice…"* – Ngenzeni.

> "*I never wanted this but then I have tolerated this because my parents chased me away from home*" – Thokozile.

The male partner, however, either buys groceries to provide for the family or expects to be catered for and does nothing. Above and beyond fulfilling the considerable roles detailed

above, there were other stereotypical gender roles that women in the focus group discussion felt they had to do in order to feel wanted by the families of their partners.

> "*My mother-in-law was never legally married to my father-in-law but she never stopped practising like a wife. Us as women have a high level of tolerance, maybe one day he would find it in his heart to marry me, in the meantime, I shall show him that he did not make a mistake by choosing me from other girls*." – Hleziphi.

4.4.7 Redundancy and male frustration

Redundancy makes people, both men and women, less human and to men, it is the foremost source of frustration. However, the most undesirable consequence is felt by women. According to the census conducted in 2001, there were more women than men in South Africa, and the female population was, on average, poorer than the male population. Sadly, most South Africans are indeed living in poverty. The root causes of this poverty can be traced back to the period of subjugation in the seventeenth century and nineteenth-century colonialism in South African history (Iliffe & John 1987). It has been noted that some men abuse their partners because they are frustrated that they cannot support the family as expected of them, and the easiest way out is to transfer such frustration onto the wife and children by ill-treating them. One participant found herself being abused by her unemployed fiancé because she was the only one who could support the family financially. The fiancé did not have financial power and the only power he had, and that he could demonstrate, was physical.

> "*I am employed as a general worker at the local B&B and my fiancé is unemployed. Every month end we fight over my money. He would demand me to buy him some beers, saying I am being selfish and I think I am a man of the house just because I am working. He would then start insulting and at times beating me up and I would end up giving him my little money and we would suffer the whole month with not enough grocery*." – Londiwe.

A similar situation was described by a second participant:

> "*My partner got retrenched from the coal mines in Dundee and he is always frustrated and he takes his frustrations out on us*." – Ntombizonke.

Even when a woman starts to speak out about the abuse she is experiencing she is unlikely to be believed because in most cases people would see the man as a modest person who respects the people in his community. The findings have revealed that by resorting to abuse, the man is overpowering his emotions of anger and projecting them on to his family, as they are a soft and easy target. It emerged in the interviews that some women have had disturbing thoughts like murdering their partners due to the physical abuse taking place. A woman, however, would think of the people around her and especially her children and decide to accept the situation as it is. This shows that IPV is overwhelming against women in particular. This was confirmed in the focus group discussion by one of the women (and supported by the other participants):

> "*I am the pastor's wife from the … Everyone from church thinks I have the most perfect life with my husband and kids. I struggled speaking out about my husband's abusive ways. Whenever we had a small argument my husband would end up beating me. He would make it a point that he never touched my face but he would kick me on the stomach and ribs. He would do this to hide his evil ways. The congregation knew my husband as a sweetheart who wouldn't even hurt a fly. The abuse went on for months. After each attack, he would feel remorseful and would help with dinner preparations and seeing the kids to bed*." – Thobekile.

Reflecting the support for Thobekile's view is the following:

> "*It is very true lady pastor; we would all think you are living the perfect life. You are very strong I must say*…" – Jezile.

According to Gnanadason (1996), many studies have shown that men who ill-treat their families are seen as gentlemen in public.

4.4.8 Romantic jealousy and feelings of insecurity

Many women often find themselves being violated in their intimate relationships because of their partners' insecurities. A man who is always insecure is dangerous because he is likely to use violence against his partner through concern that she will abandon him for another man. Jealousy and insecurity manifesting in the form of physical and verbal abuse were confirmed

in the interviews. Edelati and Redzuan (2010:498) described romantic jealousy as "a strong negative feeling resulting from the actual or threatened loss of love to a rival".

> "*I am actually sick and tired of being accused of cheating by my partner, I stay with him, even if I wanted to but I could not. If he ever contacts me telephonically and finds that my phone is engaged, I am in big trouble. He will conclude that I was busy on the phone with another man. Also, when he tells me that he loves me and I do not reply back the same way he thinks that I have found another man and I am fooling around with him*" – Zamile.

> "*My friend's fiancé never trusted her, he actually demanded her to be by his side all the time because he felt that if he was not with her, she was with another man and that if she devotes more time with her friends, they will make her do wrong things … Another friend of mine was beaten up by her boyfriend beyond recognition because he saw her with another male friend in the mall. He actually did not want her to have male friends because he did not trust that they could have an innocent relationship that does not involve intimacy*." – Cici.

Vandello and Cohen (2008) claimed that jealousy could be construed as a sign of affection, concern, caring and expression of love. Nevertheless, evidence from several countries has shown that spousal assault is triggered by sexual jealousy and suspicions of infidelity (D'alessio & Stolzenberg 2010). Ironically, men that suspect their female partners of sexual infidelity are themselves frequently disloyal but seek to control their female partners by being possessive (Rocca et al 2009; Gage & Hutchinson 2006). A study conducted in New Zealand on young women with jealous partners found that the partners monitored the women by checking on them through text messages, phone calls or other means (Towns & Scott 2013). Furthermore, the young women mentioned that they had to dress in a manner prescribed by their partners. Whereas at first the criticisms levelled by the partners seemed to be minor and understood, they (the criticisms) escalated and became stressful (Towns & Scott 2013). The young women participants felt that such criticism caused them to lose their identity and pleasure in their lives (Towns & Scott 2013). Most of the Msinga women in the current study had accepted this kind of jealousy as to them it displayed traits of true love.

Studies have found that in some instances jealous men would prevent women from leaving the house, contacting other people, or talking to anyone (Fenton & Rathus 2010; Wilkinson & Hamersclag 2005). Goetz et al (2008) added that if women leave the house and arrive later than their normal time, their partners would examine their cars for signs that they have been with other men. Some men are found to feel the need to carefully monitor a woman who is of childbearing age (Goetz et al 2008). If she falls pregnant, these men would be hesitant that the child is theirs (D'alessio & Stolzenberg 2010) and afford no support during the pregnancy. Once the baby is born, they would demand a paternity test (D'Alessio & Stolzenberg 2010). This was confirmed by one of the women participants:

> "*I remember when I was pregnant with the second baby, he called all his elderly to come and confirm if the baby belonged to his family. That really frustrated me because I only sleep with him, God is my witness to that*." – Celimpilo.

The findings of this study confirm that women are indeed in trouble with regard to jealously-related IPV. Wilkinson and Hamersclag (2005) pointed out that when women try to leave their jealous boyfriends, they faced being stalked. Men usually stalk women because they feel hurt when women leave them and want them to pay for doing so (Hegarty et al 2013).

4.4.9 Disgrace of divorce in the Zulu community

Usually, when a man and woman marry, particularly in the church, they vow to God and to the public that they will be together until death does them part. There are still couples that happily sustain this while others remain faithful to such vows despite the pain and suffering incurred by IPV. At times the partners are obligated to stay together because they want to raise the children together and support each other financially. Community and/or family pressure can force couples to remain together even when there is nothing left in the marriage to stay for. In some communities, such as those in rural areas, once you are divorced, you become an outcast and a disgrace because you have failed to remain true to your vows. To avoid this, women choose to rather remain with their abusers. The humiliation of divorce in the community was made clear by two of the participants:

> "*I am a victim of abduction but I learnt to love my husband. I am now married to him and he has never stopped abusing me but guess I will never go back home. When I left*

home for this marriage, I was told that there was no more space for me – I was as dead to my own parents." – Jezile.

"*To avoid all these nasty names you are given after leaving your marriage one opts to endure abuse …Very few people are happy in their marriages and we all know that, so why run?*" – Khanyisile.

The fear of having to endure the scorn of the community and getting stigmatised makes violated women keep silent. Some abused women do not have confidence in traditional leadership, including chiefs and *izinduna*, playing a role in protecting and helping them. Most women continue to endure abuse simply because they are responsible for house chores, as well as supporting men psychologically and emotionally as per their wedding vows. It is, therefore, the added responsibility of a woman to absorb all the pressures of the workplace so as not to distract the home atmosphere. Notwithstanding all this, women opt to stay. As noted by Gnanadason (1996:24), many women "... around the world stay imprisoned in a painful and sometimes even dangerous home environment."

4.4.10 Children and the wider family

Children are considered a countless blessing from God, a foundation of intense joy for their families and the future of our humankind. The deeds that do not recognise children's rights and protect their dignity cannot lead to a more just and nonviolent family as they go against the very values that determine and reinforce objective moral categories. In some instances, it is because the woman is concerned for her children that she bears abuse from her partner. Comments from three participants in the focus group discussion further illustrate this:

"*At least my husband accepted the boy that I got out of wedlock so if I leave him now, what would happen to my son and to his children I got with him?*" – Kholiwe.

"*I have got two sons; they definitely need a father figure so if I decide to leave who would they look up to?*" – Cici.

"*Only if I had no children, I would have left a long time ago*." – Ntombikhona.

Almost half of the participants stated that they would not wish to see their children growing up empty and emotionally drained without a father figure around. They remained in abusive marriages for that reason. A further reason was the financial factor – where a woman feels that she will not be able to survive outside of the relationship as an unemployed person. Typically, abusers taint women's dignity by making them feel that they are helpless, nothing, useless and that no one will accommodate them should they leave the relationship. Doing so creates the impression that abusers are doing the women a huge favour by keeping them.

Some women feel that they cannot cope with the pressures of daily life without having a shoulder to cry on. They believe that there is no security in the home without a male figure that takes authority.

From both the individual interviews and the focus group discussions, it was evident that IPV also affects children in many ways. Some children become withdrawn and aloof, some observe what is happening in the home and become bullies, while some become very vigorous and noisy. Participants also revealed that their children were now becoming bullies in that they were growing up seeing their fathers and other men hitting women and, in a nutshell, were being socialised or groomed to follow the same path as their abusive fathers. This is extremely worrying as it points out that IPV will continue if not prevented now.

It was evident that the mothers were willing to shield their children regardless of what they themselves were experiencing in their marriages. It became apparent that their husbands, boyfriends and fiancés becoming violent was not their (the women's) fault. In the focus group discussions, it often appeared that men would regard women as useless and nothing and classified them as children. In terms of the latter, some men would refer to their women partners as "my children". Men believed that when their partners have done something wrong, they must be disciplined and reprimanded as parents would do to their children. This puts women in an intimate relationship in an inferior position. Whilst the understanding is that IPV happens only among the underprivileged and dis-functional families, findings from the interviews show that this is not true. Some of the interviewed women were not poor.

4.4.11 Fairmindedness and quietness

It is never easy for women to gather the strength to divulge the violence they are experiencing to people outside the family. Some violated women opt to remain quiet either because their husbands are well-respected and thus do not want to embarrass the community or because they see that there are no benefits in speaking out. Their remaining quiet reflects that they have lost hope in getting support, including support from traditional leadership. Remaining quite was the only option. Two participants confirmed this:

> "*I keep myself busy with looking after children in my crèche. I do not have time to talk because even if I talk nobody will listen to me*." – Duduzile.

> "*Nobody listens to you if you complain about your husband. It is even worse if you stay with your parents-in-law. We go as far as to protect our husbands' images from the community we live in*." – Nompumelelo.

Fairmindedness and quietness can become an obstruction to the liberation of victims of IPV Furthermore, most women experience more violence in their households than elsewhere (Moreno-Gracia et al 2009). As homes are perceived as private spaces, "it is difficult for the family, lawyers, police officers and judges to intervene when violence occurs" (Fox et al 2007:597). When women decide to report their abusers, they face various challenges. The perpetrators might threaten to kill them if the case goes to court and they are convicted (McDermott & Garofalo 2004). Other perpetrators go so far as to threaten to kill themselves if convicted (Hanner et al 2009). Should a woman not withdraw her charge, the perpetrator could abuse her again before the trial to demonstrate that he is serious about his threat (Jordan 2004).

4.4.12 Uneven distribution of authority in intimate partner relationships

How IPV is described in South Africa gives the impression that IPV is rooted in the uneven distribution of power within intimate relations with patriarchy, women being financially dependent, poverty and exposure to the culture of violence all playing a role (Mazibuko & Umejesi 2015). This theme emerged from the participants' experiences, perspectives and interpretation of power relationships in their previous and current intimate relationships. The Msinga women participating in the study firmly acknowledged that the power relations between them and their male intimate partners were not equal. The following explanation provided by one of the staff members concisely captures the modalities of these relationships:

"*We cannot sit here and pretend as if we do not know that in our culture, it is with no doubt that our intimate male partners ought to be given the leading role, failing which the relationship is bound not to succeed. We conform to this even when our partners are not gainfully employed. The learnings are further emphasised in our churches that we are affiliated to, where submission to male partners is highly anticipated in order to sustain our marriages and relations*." – FGD#1.

Owing to the uneven power relations between women and their partners, they (the women) are typically excluded in the decision-making process in the household even though most of the decisions concern their lives. An interviewee voiced the following:

"*Who am I to share my thoughts, because I am just a trophy wife with no brains. I am even told when to go to town to do our grocery*."– Nompumelelo.

The lesson learnt from the above quotes is that there is a noteworthy enforcing of unequal power relations and controlling behaviour by the participants' male partners. It can be suggested that the unequal power relations between the women participants in Msinga and their male partners are based on beliefs that condone male dominance and female subordination and are rooted in patriarchy.

4.4.13 Intimate partner violence regarded as a private matter

Almost all participants agreed that violence between intimate partners is a confidential matter that should be kept as such, particularly for married couples. Interviewees shared the following:

"*You will be a fool alone sharing your own stories regarding your relationship while others are sitting on their problems*." – Tholakele.

"*When I left home my mother and other women from the family sat me down and advised me that I am now a woman and I should never hang my dirty laundry for everyone to see, what happens in my house should stay in my house behind the closed doors*."– Khathazile.

"*We were socialised with the knowledge that violence between two intimately connected adults is a private matter. Our grandparents and parents suffered in silence and here we have grown into the women we are. There is an idiom in Zulu culture: Akukho siziba esingahlokomi [there is no single household devoid of challenges]. After all, akukho soka elingenasici [no man is perfect] and as a result, we are not the first lot to suffer violence and all men are the same, you can't change them all*." – Nompumelelo.

The findings revealed that culture exerts a substantial influence in reinforcing unequal power relations and controlling behaviour between abused women and their male partners, all culminating in IPV. Most women in an abusive relationship choose to suffer in silence as they strive to protect their families.

"*I was in an abusive relationship with my late husband. My family never knew about the abuse until I was hospitalised because my late husband would pretend as if I am the best thing that ever happened to him, so everybody thought we are a very happy couple. He never allowed me to have friends, so I could not talk to anyone. We were married for five years. We had two children. He was so controlling from the first time we met, he mentioned that his ex-fiancé cheated on him so he does not trust easily now. He had trust issues, low self-esteem and anger issues. The emotional abuse gradually became more intense, and then the physical abuse set in. He would constantly beat me in front of the children sometimes he would even kick us (with the kids) out at night. So, this one day he beat me up until I was unconscious. He left me lying down on the floor, I tried picking myself up and called an ambulance. That when my family found out that I have been living a lie. I opened a case against my late husband and he was granted with a protection order and my family organised a social worker for me to talk to. While I was still at home, he then passed on but I am still not sure if I have forgiven him or not*." – Tholakele.

It became apparent that most participants grieved in silence rather than exposing the violence they encountered in their households. This was done under the guise that "no family is perfect … we are not the first victims of this violence and we cannot end it". This also revealed a situation which could spiral into incidents of marital rape. The findings did disclose that marital rape occurred but it was perceived as normal with the result that such incidents were not spoken about.

While the DVA demonstrates real progress in dealing with the problem of domestic violence in South Africa, when it comes to dealing with domestic violence in the rural areas the act faces clear challenges (Bower 2014; Chuma & Chazovachii 2012). According to Arts (2010), there has been little progress in enabling rural communities to access the criminal justice system. The rural areas commonly lack sufficient services including police stations (and special units) to report abuse as well as psychological support agencies and shelters (Bower 2014; Davhana-Maselesele et al 2009). This makes it difficult for women in a rural community such as Msinga to access support when they are confronted with IPV and which is reported to be particularly high in these communities (Bower 2014). Raising awareness of IPV also continues to be very limited in rural areas due to a lack of activism on the issue (Vetten 2005).

4.5 SUCCESSION OF VIOLENCE

During the discussions and the interviews with the study participants, it was noted that they had experienced the three stages of domestic violence that the women survivors of IPV go through, referred to as the cycle of domestic violence. While this cycle defines a pattern of violence it does not necessarily explain why domestic violence happens (Dlamini 2005). The violated woman has little or no control over the cycle of domestic violence as the abuser controls its every phase. Often when the abused woman is advised by someone to leave their abusive partner, she will agree to do so but sooner than anticipated she will return to the abusive relationship. Most women in abusive relationships love their partners and do not want to be separated yet, at the same time, they do not want the violence to continue. The cycle of domestic violence is reflected in Figure 1 below.

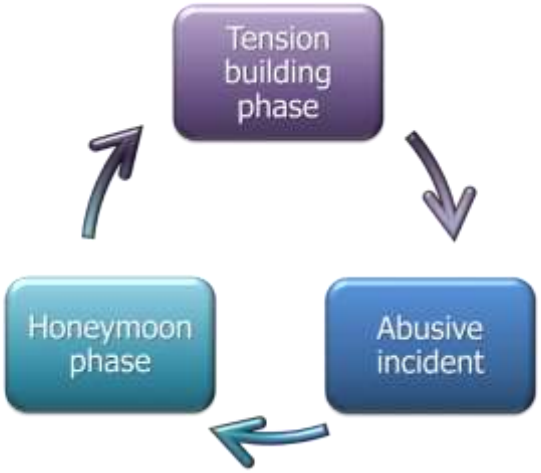

Figure 1: The cycle of domestic violence
(Source: http://www.center4research.org/cycle-domestic-violence/)

IPV often follows a repeating cycle within each relationship and it is acknowledged that not every abusive relationship follows this pattern. However, many survivors describe their relationships in this way and the participants were no exception. One participant narrated the following:

> "'*Baby I'm sorry for what happened last night I swear it won't happen again.' That's what he always said after a hectic night of drinking. Whenever my boyfriend went out drinking, I know when he comes back, he will be violent and call me names. I would hear him at midnight banging my door, 'Open this door you b*&#h, I'm starving, did you cook? What's taking you so long to open the door? Are you with a man in there? I swear I will kill you both.' I had to endure that every night. The kicking will then follow. A few days later he would be apologising again*." – Khanyisile.

It is for this reason that it is argued that IPV never stops but it has phases and the situation may lead to femicide or homicide. A second participant stated the following:

> "*He did not even want me to go church, I will go to church when he is not around. One day he found out that I went to church, he beat me up and forced me to move out with my kids. I went to my mother and she called a family meeting with my in-laws. The matter was discussed and everything was sorted. My husband apologised and I went back to my husband. He was so romantic only for a week. His abusiveness came back, he will wake me up at night and demand food and sex, when I refuse, he beat me, there*

is this day I refused he beat me and lost my front tooth. Afternoon on that day he came back with flowers and chocolates and he apologised. He never stopped abusing me it became a norm to me. Until I decided to report the matter to induna and that's when I got helped." – Thobekile.

Some women tend to normalise abusive behaviours and so find it hard to identify their relationships as abusive and thus do not feel the need to seek assistance. In some instances, a woman is unable to point to exactly when the violence happens in her life. On the one hand, she is hopeful that the situation will improve as the man promises that he will change. On the other hand, some women are satisfied with living in a marriage that is not working well; doing so, to them, has become a norm. Often, as reflected in the accounts above, when an abusive situation happens it is followed by the abuser doing something nice or apologising and promising that they will never do it again. A third participant described the following situation:

"*My husband and I were married for six years. Our marriage had its ups and downs, especially because I couldn't give my husband children not even one child. We've consulted different doctors including traditional healers. At some points, my husband would be so supportive and sometimes became a monster. He would even say he curses the day he got married to me because I can't fall pregnant and that hurts me so much because this is all my fault. He always reminded me that I am just an item of furniture since I can't even give him children. Even his parents were insulting me about being unable to give birth. I have tried everything to get a child but it didn't work. His family also proposed that he must take a second wife that can give him children. Emotionally I was abused by my own husband and his family*." – Bongiwe.

4.6 TYPES OF INTIMATE PARTNER VIOLENCE IN MSINGA

Even though the analysis of the findings reveals a comparable pattern in all the relationships, the IPV experienced by the study participants took various forms. All the participants confirmed that their relationships involved some form of physical violence. For two of the participants, physical violence only happened on two occasions. Several of the participants experienced physical and psychological or emotional violence on a daily basis. Some participants stated that they were involved in forms of sexual violence. Disturbingly, in some of the IPV scenarios shared, the sexual violation was of a very severe kind.

Distress is a central theme in the narratives of women experiencing IPV. The whole process of breaking up is infused with feelings of distress and these will be revealed by way of excerpts that originated through the analysis. With distress follows uneasiness and worry, stress, a sense of chaos, shame, anxiety, confusion, ambivalence, trauma, emotional bonds, shock and terror. These different manifestations of distress can prevent women from leaving toxic relationships. They were expressed in many different ways when the women participants talked about the violence, their partners, children and the separation.

The quotations below illustrate the forms of IPV experienced by the Msinga women participants. Some of the participants were comfortable to speak out about their experiences concerning IPV incidents.

4.6.1 Physical abuse

The women confirmed that they were physically abused by their partners and sustained injuries as a result of the abuse. Some women pointed to sustaining multiple injuries while others described their injuries as bad. The participants called their bruises "survival scars". The abuse from their partners comprised scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, slapping, punching, burning and use of a weapon. Participants mentioned that these forms of abuse are hard to hide from people. Despite not being ready to relate their experiences to others, they would be pressurised by people to do so. It was at this point that they would create stories to shield their male partners.

> "*A few months after I got married things started to go south. My husband turned me into a punching bag, he would literally beat me up for nothing, I think the sight of me disgusted him. This went on for years, he claimed I did not respect him. I guess I was not submissive enough. We always had silly fights since I was not able to conceive*." – Khathazile.

4.6.2 Sexual abuse

A few individuals shared their experience of being compelled to engage in a sexual act against their will. Some men would sexually abuse women under the pretence of love and some under the pretence of culture.

> "*I am the victim of ukuthwala. I had to learn to love my husband*." – Ntombizonke.

> "*If I refuse to have sex with him, he says it means I do not love him*." – Cici.

> "*My husband would come home drunk and demand sex. There is nothing painful like having sex with a drunk person*." – Nompumelelo.

4.6.3 Psychological/emotional abuse

All participants identified with this form of abuse that involves trauma to the victim caused by acts, threats of acts or coercive tactics. Almost all the participants recalled being humiliated by their partners at some stage of their relationships. Some mentioned that they were controlled as to what they could and could not do. They also pointed to how some information would be deliberately withheld from them. Their male partners would do something to make them feel diminished or embarrassed, isolate them from friends and family, and deny them access to money or other basic resources.

> "*I remember this one day when he said marrying me was a waste of time and money, he is giving me this month to fall pregnant or else he is taking a second wife. After a month I couldn't fall pregnant again. I was then forced to accept the second wife who will give him children. I had to be part of the wedding planning for my husband to marry another woman and they got married. I am just a nobody to my husband now I feel like I am an intruder in my house … There was a time where I was very sick it was like I am losing my mind. I was then admitted to the hospital for depression. But he never cared about that*." – Thobekile.

4.6.4 Forced marriage

Forced marriage disturbing in that, amongst other consequences, it diminishes a child's rights. It is one of the reasons for the South African government ratifying the African Charter on the

Rights and Welfare of the Child in 2000, including Article 21 on the prohibition of child marriage (Kaime 2009). In a further response, the government in 2004 ratified the African Charter on Human and People's Rights on the Rights of Women in Africa, including Article 6 which sets the minimum age for marriage at 18 (Viljoen 2009). The issue of forced marriage is now in the hands of the relevant service providers who need to assist the South African government in sensitising the people they are serving with this information.

> "*Twenty years ago, my father married me off to a 30-year-old man; mind you I was only 15 years old*." – Khathazile.

4.6.5 Secondary victimisation

In most instances where women survivors of IPV seek legal and medical assistance, they end up being blamed for any wrong done in their relationships. They thus become reluctant to seek further help. Participants in the study pointed out that when they reported cases of sexual abuse, they were asked questions such as: How were you dressed at the time of the incident? Who witnessed that? Why didn't you report on time? What did you do? …and so forth. In present-day South Africa, one of the country's challenges is that of rising crime levels. While IPV is among the predominant crimes facing the country, numerous incidences of such crimes go unreported to the police, or when reported, are withdrawn before trial and with the result are not acted upon. Extensive research attributes the non-reporting of incidences of IPV and/or withdrawal of charges of IPV to factors such as the victim's dependency on the perpetrator for financial support, insurance and shelter and the avoidance of shame and judgement by society. There is, however, some research that indicates that victims of IPV experience secondary victimisation when seeking help from the police and this was also confirmed in the findings of this study. This study found that secondary victimisation of victims of IPV is perpetrated by the police when victims seek help from them. It has also been found that their experiences with the police influence the IPV victims' attitudes towards future assistance seeking. Even though the police are not the cause and/or perpetrators of IPV, their demeanours when dealing with and treating victims play a very significant role in encouraging confidence in the country's justice system. When done correctly, one will arguably see more victims of IPV coming forward to seek help, thereby working towards eradicating the problem.

"*I tried to report my matter to the nearest police station but they told me that my case was not a priority because what we do, we come and report and the next thing we withdraw charges so we are wasting their time, they have serious cases they need to attend to. That was my last time going there*." – Nompumelelo.

Furthermore, during the interviews, it was found out that some women experienced secondary victimisation by their husband's family when they were suspected of killing their husbands. Husband's families sometimes think that women get revenge by murdering their husbands as they (the women) think that it is the only way of escaping the abuse.

"*My parents-in-law and police found me as the first suspect for killing my husband. I had to go back and forth to court attending the court case. I am so thankful to my ancestors that I was not found guilty of murder but till to date my parents-in-law have not found peace in me*." – Tholakale.

These victim-blaming attitudes, behaviours and practices engaged in by community service providers contribute towards additional trauma for IPV survivors thereby causing more damage.

4.7 REASONS FOR WOMEN STAYING IN ABUSIVE RELATIONSHIPS

When most people hear that someone is in a toxic or abusive relationship, their first question is, "Why don't they leave?" If one has never been through an abusive relationship, this sort of response might appear logical – a case of simply "throwing the deuces up" and moving on with one's life. However, when it comes to abusive relationships, it is never as easy as "just leaving" and most researchers have confirmed this. During the focus group discussion, the women survivors of IPV shared their reasons for staying in abusive relationships regardless of the circumstances and these included that they still loved their abuser. Some women stay in their abusive relationship, sticking to their vows until they reach their graves. Other women do so out of respect for their family in-laws. One participant narrated the following:

"*In the following morning, while he went to work, I also went to my mother-in-law to tell her about this issue. Surprisingly, she told me I need to be strong and do whatever*

my husband asks as a wife. I cried day and night and prayed about this situation. My husband will come back very late and he will demand food and sex at night. One day I refused to sleep with him and he beat me up until I couldn't even feel myself. I didn't want to worry my mother about my marriage problems so I kept all these as a secret. The young girl gave birth and the child was brought to me when she was only 5 days and I had to raise her as my husband said so. So now I had to tell my family about this child and they were all mad but they said I shouldn't give up on my marriage. My husband was no longer giving my children attention it was all about this girl. When I tried talking to him about this, he will become aggressive and beat me." – Zothile.

Leaving an abusive relationship is not only emotionally challenging, but it can also be life-threatening. In actual fact, the most dangerous time in an abusive relationship is post-break-up. Women are more prone to be assaulted by their former partner after leaving their abusive male partners than at any other time during the relationship (Fleury et al 2000). Thus, staying in an abusive relationship is sometimes understandable as the women would believe that they are not protected by the law enforcers.

As I am involved in working with women who are attempting to leave abusive relationships, it frequently happens that women attempt to break up with their intimate partners several times before the breakup "sticks". This is the opportune time for them to be provided with support. They get comfort and confidence from being assured that they are being supported for the entire journey.

A study conducted with women living in shelters revealed that they had experienced stalking after ending their relationships with their partners (Mechanic et al 2000). The man may terrorise or harass the woman by making recurring phone calls, sending intimidating letters and emails, conducting surveillance at work, home and other places, and vandalising her car or other possessions (Bradley 2000). This puts women in more danger and their freedom is taken from them as they cannot move freely and are forced to watch their backs at all times. It has been found that jealous men do not necessarily use all these tactics but the ones that work for them (Kelly & Jonson 2008) as they would have known the weaknesses of their female partners and would tend to capitalise on those. At times even those who are close to the abused women find themselves at risk of being victims themselves. Kelly and Johnson (2008), for example,

found that men who stalked their partners sometimes extend their tactics to the woman's family, colleagues, pets, children and property.

> "*I once tried to leave the relationship as my friends were advising me but it did not help as he was following me where I go*." – *Cici.*

Lack of family support for leaving an abusive relationship was noted in most of the responses as a reason for abused women to stay in such a relationship. Women are encouraged by their sources of reference to tolerate issues of IPV and told to be strong. Because these women do not want to disrespect their sources of reference, they would endure abuse. Some women would be blamed for the abuse that was happening in their lives as outlined by one of the participants:

> "*I tried talking to my mother about this issue but she asked me, 'What did you do wrong for your husband to beat you up?' She made me look like the bad person*." – Khathazile.

Most of the interviewed women in Msinga experienced extensive IPV and their girl children were substantially more negatively affected by the violence than their boy children.

4.8 EFFECTS OF INTIMATE PARTNER VIOLENCE ON WOMEN IN MSINGA

IPV affects survivors or victims in several ways and is highly likely to have psychological and other health consequences. According to a literature review by Campbell (2002), injurious physical and mental health sequelae of IPV include injury or death, chronic pain, gastrointestinal and gynaecological problems, depression, and post-traumatic stress disorder (PTSD). It may also lead to loss of self-esteem, weight loss, phobia of being alone with their partner and termination of the relationship.

> **"***At times things work out after the fight you had, and at times they do not, depending on the nature of violence*." – FGD#1.

4.8.1 Physical injuries

Many women shared that it was very common to sustain injuries and very few would tolerate that. Women who experienced physical violence in their relationships sustained physical injuries or bruises as a result of the abuse. This is one of the main health consequences of violence in relationships. One in three partnered women worldwide has experienced physical and/or sexual violence by an intimate partner. Of these women, 42% sustained immediate physical injuries and 13% were fatally injured (WHO 2013). In some instances, the injuries affect their physical appearance and they end up with facial scars. At times the injuries are so severe that they require medical attention. This form of abuse is the most recognised form of abuse by the Msinga women participants.

> "*I was still fine when he was still insulting and calling me names and it became tough when he started beating me up. I had facial injuries, bruises and a swollen mouth when I decided to call for help*." – Velephi.

> *"I know a few couples that use knives when fighting. They always go to COSH [a hospital] because of injuries from stabbing*." – (FGD#1.

> "*I was burnt by my husband and sustained severe injuries following the burn but my husband never said sorry till to date. I was admitted into the hospital and I had to lie trying to protect him from going to jail. If I had exposed him, my children were going hurt and the other sister-wives were going to hate me forever*." – Ntombikayise.

Several participants agreed that some abusers often make sure that the injuries are not visible to other people. To avoid public display of their abuse, the abusers would hit their female partners on parts of their bodies where the injuries would not be visible to anyone but the victims themselves.

4.8.2 Ending of the relationship

The study found that there were various reasons for women deciding to end their relationship after an act of violence. For example, they were frightened of being with a partner who had previously violated them and were afraid that the behaviour was likely to be repeated. Two participants who made the "break" stated:

"*It took me years to end my relationship with the man who used to beat me up in front of my children, leaving me with unbearable bruises. He was surprised when he was told that I had gone back home. But I believe that us as women, we attract people of the same character, as I speak to you, my current partner has some abusive traits but at least he does not hit me*." – Funani.

A second participant, in support, said:

"*I also ran from the man I loved because there was too much of beating. At least with the one I am currently with now is only insulting when he is drunk*." – Thobekile.

It was discovered during the interviews that most women often go through a long process before deciding to either end the relationship or continue. It needs to be acknowledged that it is not every woman that would tolerate an abusive relationship. Some women are able to leave a toxic relationship they are in even though it may take some time for them to realise that they need to do so.

"*I have been in an abusive relationship with my ex-boyfriend. In the beginning, it started with little things like calling me names when I was going out. He would accuse me constantly of cheating and began checking my phone, disapproving of male friends despite having female friends himself. If I refused to have sex with him, he would threaten to hurt me. He used to beat me up in his room when there is just the two of us. He would go missing for days, when he came back, he would want me to accept him again without questioning him about his whereabouts. He used to beat me up and after that, he would apologise and also blame me whereas he was the one who disappeared on me, he would say it is because he loved me. At a later stage, he would beat me in public – that's when I made the decision that enough is enough, I am leaving this relationship. It is like I was cursed because my current partner is also abusing me. I think I am attracting people with the same traits*." – Londiwe.

This statement reveals that some forms of IPV abuse can be tolerable to some women in that they are seen as less harmful than other forms. However, physical abuse was perceived as the worst form of violence by the women survivors participating in the study.

4.8.3 Self-deprecation and self-blame

By and large, the women participants reported feeling less worthy after being in a violent relationship and some felt that they were not appreciated. Moreover, they reported having difficulty in trusting others and being in an intimate relationship. Some women felt that they were continuously being monitored by their male partners and this had eroded their self-confidence. They were fearful of speaking publicly about it because it might lead to further abuse. At times women blame themselves for triggering the acts of violence by their male partners**.** According to Terry and Leary (2011), self-blame is the process of attaching responsibility for conditions or events to oneself in a hostile, disapproving manner. Scott and Straus (2007:853) explained blaming as follows: "Blaming refers to the attribution of causality to factors outside the self." For instance, "if you had not done this, I would not have done that." In this study, the notion "self-blame" was found to be more prevalent than the concept of "blaming". Self-blame for women survivors of IPV was discussed more during the focus group discussion and four participants mentioned it in the individual interviews. Women survivors of IPV appeared to blame themselves and portrayed the impression that they deserved to be violated because of what they did or did not do.

> "*I had no choice; I could not give him children so he had to take a second wife even though it did not sit well with me*." – Bongiwe.

> "*I lost my self-esteem after the day I asked myself why I let him abuse me like that. I ended up being too scared of him even if he did nothing to terrify me. I could not associate myself with other people, it felt as if they were seeing what I was going through. Every person was pitying me*." – Zothile.

> "*I am seriously anxious about my weight because I do not even know what to do about it anymore. I seriously do not know how to change the way I look into something that he will appreciate. He thinks I eat too much food when I am home alone. I am not sure if this happens to you whenever my man calls, I need to ensure that he gets me over the phone. For me not to get insulted I need to have my phone with me all the times otherwise I would be told that I was busy with other men. I now have to make sure that I give him first preference over other people*." – Thembani.

Acts of violence in relationships are also likely to lead to the isolation of victims from the outside world. The quotations above show that a violent partner is likely to be jealous of his partner's social interactions and will control her movement. He may keep her from seeing or talking to family or friends, or even prevent her from going to some gatherings. She may end up having to ask for permission to talk to anyone, go anywhere or see anyone.

4.8.4 Unhealthy eating behaviour

It has been found that some abused women are more likely to suffer from eating disorders. A significant number of the Msinga women participants stated that after experiencing abuse they would either gain or lose weight. This was a result of the changes in the way they ate due to the stress caused by violence in their intimate relationships. Violence frequently leads to psychological problems and people deal with these problems in different ways. Some women tend to eat more than normal when they suffer psychological problems associated with IPV while others tend to eat less. This was viewed by most of the women as a concern since their male partners would complain about their physical appearance.

> "*When I was stressed, I would normally find myself losing appetite, and often if you do not eat a balanced meal you lose weight even though it is not major*." – Jezile.

> "*My partner always complained that I am too skinny, I am just a disgrace to his family and that forced me to begin eating a lot more than I normally do hope to gain weight and wear at least a size 38 but unfortunately God created me the way I am. He would even say his ancestors are looking at this tiny girl in the yard and not recognising her as a daughter-in-law*." – Khanyisile.

Tjaden (2000) argued that the victims of IPV have a high incidence of stress and stress-related illnesses.

4.8.5 Sexually transmitted diseases

Some participants strongly felt that being in an abusive relationship lessens chances of health communication and safer sex negotiation.

"*My husband would go to his place of work and come back demanding unprotected sex from me and I knew that he had different mistresses and as we speak, I am HIV positive. I would go to different traditional healers trying to treat some infections in my private part thinking that his girlfriends were bewitching me, only to find that I was already infected with this disease*." – Zamile.

Patra et al (2018) confirmed that women in violent situations are less able to use contraception or negotiate safer sex and, therefore, run a high risk of contracting STDs and HIV/AIDS.

4.9 CONCLUSION

In responding to the first key research question on women experiences of IPV in Msinga, the study found that the participants were subjected to more than one form of IPV from their male partners including emotional, physical and economic violence. However, physical and emotional violence appear to the common forms of violence experienced by the women. The findings of this study are in line with those of previous studies which confirm that many women who are physically abused are also abused emotionally (Slabbert 2014). Numerous researchers have also confirmed that women suffer multiple forms of IPV such as emotional, physical, sexual and economic violence (Leiner et al 2008; Pineles, Mineka & Zinbarg 2008). A concerning observation is that while IPV is still prevalent among women it is not spoken about despite the overwhelmingly negative effect it has on the lives of women. While the study gathered noteworthy information from the women participants, it is imperative to acknowledge that IPV is a complex social problem intensified by multiple factors. This study recognised low economic status and culture as influential factors in the occurrence of IPV. It appears that women with low economic power are most likely to face IPV and not seek help because they depend solely on their male partners for survival. The findings also show that women's access to financial resources in the household is highly controlled or restricted by their male partners. Most participants who remained in abusive relationships did so due to their financial dependence on their male partners. The patriarchal notions and cultural views that condone uneven power relations between men and women frequently influence women to remain in abusive relationships. Findings from previous studies demonstrate that women with a low wealth status were more likely to experience IPV compared to women with a higher wealth

status (Ahinkorah et al 2015). Lastly, the findings revealed that women survivors have low levels of decision-making power in intimate relationships and their male partners often use power and control to dominate them.

These findings echo those of Conroy (2014) who discovered that unequal power relations and controlling behaviour on the part of husbands or partners are linked with IPV. Antai (2011) added that controlling behaviour among men is meaningfully linked with a higher likelihood of physical and sexual violence and other forms of violence by intimate partners. Zembe et al (2015:3) acknowledged that "the inequity between men and women in intimate relationships is defended by cultural and patriarchal social belief systems that endorse such power differentials". The findings of the study substantiated the view that a culture of silence surrounding IPV exists and is influenced by women's hesitancy to bring private family matters into the public domain. When scrutinised thoroughly, the culture of silence and privatisation of IPV compromise the accuracy of the national statistics on IPV prevalence as most cases go unreported. It thus becomes problematic to have comprehensive data and a true reflection of the prevalence and impact of IPV. As pointed out in this chapter, women are exposed to more than one form of IPV from their male partners. High levels of physical and emotional abuse and controlling behaviour (on the part of their partners) were often mentioned during both the focus group discussion and the individual interviews. IPV has the probability of being part of a vicious cycle and being replicated. This was discussed with some of the interviewees having witnessed IPV between their parents and they themselves subsequently experienced it with their male intimate partners. It was noted that some abusers were abusing their partners under the false pretence of love.

It is a hard truth that for as long as women are not empowered or financially independent, they will not be in a position to combat IPV as they frequently depend solely on the abusers for support and thus the silence on and often justification for the violence. Women should be empowered to resist being controlled by men and to articulate and fight for their rights against any form of discrimination and sociocultural practices that expose them to IPV. Societies should start engaging in discussions that challenge all behaviours that condone male dominance and female submission. Additionally, men and women should collaboratively engage in deliberations and debates that challenge and deal with the patriarchal notions and practices that fuel imbalances between men and women. These points will be further discussed in Chapter 8 under recommendations.

The women participants in the study implemented several coping mechanisms but when the abuse did not stop some left their partners. Ultimately, the findings show a connection between the women's personal experiences and situations and their subordination as women. Mostly, women from deprived family backgrounds with a limited education find it very hard to escape from abusive relationships. Even after they have tried to do so by finding refuge in a safe place they return to the partner, and when they are subsequently abused and injured, they do not report the incident. Their children became the core reason for their remaining in an abusive relationship. The findings confirmed that staying in an abusive relationship can do more harm than good to the children they are trying to protect. Most women were too terrified to ask their male partners about the reasons for the abuse and, consequently, they remained trapped in a cycle of violence and abuse. In some cases, it was apparent that socialisation conditions women to accept or tolerate abuse for the sake of having a man. It was suggested that structural transformation is essential for the benefit of women.

CHAPTER 5

PRIMARY PREVENTION INTIMATE PARTNER VIOLENCE STRATEGIES EMPLOYED IN MSINGA AND THE EFFECTIVENESS OF THE STRATERGIES

5.1 INTRODUCTION

I have observed what the literature says about IPV and have also examined women survivors' experiences of IPV in Msinga. I now identify the primary prevention strategies or models that the NGOs in Msinga used in combatting IPV. As discussed in Chapter 4, IPV has had a devastating impact on women survivors' livelihoods in Msinga. This was mainly as a result of the physical, emotional and psychological consequences that they suffered which made it challenging to engage in meaningful sources of livelihood. Some women survivors had lost their confidence and dignity following the physical injuries sustained during the abuse while others had been belittled through insults. Furthermore, some of the women had lost their families and friends while enduring abuse. Worse still, were the women who, following the reporting of violence, were evicted by in-laws for exposing the family to disgrace by ignoring the social norms of treating marriage issues as a private matter. For these reasons, instituting interventions geared towards countering IPV directed at women in Msinga was paramount. This chapter discusses the interventions made by the NGOs in terms of addressing the needs of women survivors of IPV including their effectiveness (or not) in doing so. Barriers which hindered the effectiveness of the primary prevention programmes will be highlighted.

There is an urgent need to advance knowledge concerning IPV prevention programmes. Innovative strategies are being explored internationally and this chapter describes and discusses primary prevention interventions addressing IPV. Primary prevention is critical in preventing IPV in that it intervenes with individuals, families and communities in ways that stop the perpetration of violent behaviours. Preventive intervention efforts have largely entailed community awareness campaigns, school-based programmes on conflict mediation, violence prevention in general, dating violence, sexual abuse and spouse abuse. Saggurti et al (2014) and the Ministry of Women & Child Development (2018) argued that, to date, the majority of

IPV prevention efforts by the government sector, NGOs and research-based organisations have focused on secondary and tertiary IPV prevention.

There is wide agreement globally across the research, policy and community sectors that the critical components of violence prevention involve promoting gender equality and addressing the multiple and intersecting forms of discrimination and disadvantage that place women at risk of violence. This includes involving all sectors of society to confront entrenched beliefs, cultural norms, and patterns of behaviour that lead to discrimination against women, stereotyped roles for women and men, and that underpin gender inequalities. Furthermore, systemic factors influencing violence against Msinga women and women from diverse cultural and social groups include issues of patriarchy, cultural norms and beliefs, entrenched poverty, and exploitation on the grounds of love. There is growing evidence that many of the risk factors that increase the vulnerability of individuals, families and communities can be transformed, including the environments in which they live and work throughout their lives. The socio-ecological model used in this study is a well-known framework which conceptualises violence as the outcome of complex interactions between risk and protective factors at the individual, relationship, community and societal levels. It can also be used to conceptualise the primary, secondary and tertiary prevention activities taking place across the various levels.

5.2 PRIMARY PREVENTION STRATEGIES

According to Fedler and Jacobs (2001:41) to eradicate domestic violence, the following should be considered: community-based programmes, research and education aimed at raising public awareness of the issue; training to ensure gender-sensitive law enforcement; and adequate healthcare, housing shelters, counselling, and support services. The most critical, however, is the need for a fundamental change in social attitudes and practices. Most academics and researchers have come to an understanding that collaborative efforts by NGOs, CBOs, communities, the state, health services and the law are indispensable in addressing violence against women (Carter 2001; Association of Men Against Violence 2002).

5.2.1 Community mobilisation

The key focus area in IPV programming has been on engaging individuals to re-examine their attitudes and on awareness-raising activities rather than engaging whole communities around

social norm change (Carter 2001; Association of Men Against Violence 2002). Community mobilisation is a promising strategy which pursues stimulating change in social or cultural norms and behaviour through community activism. It rests on the idea that effective violence prevention hinges on community members leading efforts in their community (Michau 2007). Its main aim is to shape a critical mass of individuals and groups who no longer endure VAWG.

In the Msinga context community mobilisation involves NGO programmers working together with local community members to raise awareness and communally address social challenges. Community mobilisation is one of numerous related threads of participatory social methods that draw on theories of critical pedagogy and social justice (Freire 1970, 1973). Community mobilisation interventions have addressed IPV in Msinga. Lippman et al (2018) argued that in South Africa, community mobilisation in the form of the "One Man Can" programme implemented by Sonke Gender Justice has been shown to improve HIV-related outcomes but the same approach has not been effective in reducing IPV perpetration by men in a rural setting (Pettifor et al 2018). I shall examine the extent to which community mobilisation interventions have impacted the lives of victims and survivors of IPV in Msinga.

In addition to examining interventions in robust trials, it is imperative to unpack how these intervention programmes are conceptualised and provided and why they may succeed or fail to demonstrate an effect on women's IPV related issues. The discussion will also detail how complex interventions are implemented, possible mechanisms for impact, and how context shapes delivery. The NGOs in Msinga focus on the following IPV primary prevention strategies:

5.2.1.1 Promoting community education through face-to-face programmes

In these programmes, information is communicated to individuals on a one-to-one basis and the community primarily through public meetings and encouraging word of mouth publicity. The latter is based on the belief that if you help people, they will inform others in the community. Community education strengthens awareness of IPV as a community issue and educates the community about IPV and the needs of its victims. The foremost aim is to increase the knowledge of the community so that it can deal more efficiently with beliefs about IPV and attitudes towards women who are victims or survivors of IPV. The deeply rooted social traditions and male domination in all important spheres of life (socio-cultural and political)

have led to the serious exclusion of women from these spheres. As a consequence, women have been reflected as unequal contestants in interpersonal relationships and at the extreme, they have come to be seen as possessions over which men compete (Ellis and Bettie 1983).

The key informants from the NGOs in Msinga that I interviewed stated that soon after IPV was noticed to be on the increase various actors such as NGOs, government departments, religious organisations as well as traditional leadership recognised that there was a need to include the entire Msinga community in addressing matters of IPV. It was in response to this recognition that some organisations in Msinga held joint public meetings, for example, Victim Empowerment Forums (meetings) to sensitise the community to the problem. The meetings were premised on the understanding that IPV cannot be understood in isolation from the gender norms and social structures that affect women's vulnerability. The NGOs involved included the aforementioned Khayelisha Care Project, the uMusa woMsinga Project, LifeLine and Rape Crisis and the Sinozwelo Resource Centre. The religious organisation was the Roman Catholic Church in Msinga while the government departments included the police, the DSD and the Department of Health.

Consciousness-raising on the gendered nature of the violence was done during the meetings. Other issues that were addressed included IPV being used interchangeably with domestic violence, dominant myths that propel sexual violence against women, preventative measures and how victims of violence are treated. Small groups were used during the meetings to deliberate on the issues. The consciousness-raising was critical since socio-cultural factors which include attitudes, norms and beliefs about women and violence play a major role in how communities respond to incidences of IPV (Frecero et al 2011).

According to Beatrice (a social worker who participated in such meetings), several issues arose during the discussions. These included factors that fuelled GBV and IPV such as indifference and unruliness within the community triggered by unequal distribution of power, cultural norms, on-going political violence within the community, high poverty levels and the negligence of the security forces to address matters of insecurity within the community. Other major factors pointed to include the perceptions of men towards women in the community – women were perceived as inferior to men and men took advantage of this to abuse women during the violence. Following their perceived supremacy in the critical spheres of politics and economics, men see themselves as superior vis-a-vis women. As argued by feminist theorists,

to eliminate GBV the disparities that exist between sexes in matters of socio-political and economic power must be eradicated (Hilberman 1976; Clark & Lewis 1977). Thus, interventions aimed at promoting gender equality and the empowerment of women and girls were suggested. These included enhancing equal opportunities to education and justice and the political and economic arenas. Other critical matters raised during the meetings were the appalling attitude of staff at government departments towards victims of GBV, HIV/AIDS prevalence within the community, the increase in female-headed households as a result of wives being deserted by husbands after learning that they were living with HIV, and increased poverty levels within the community.

Organisations such as the Khayelisha Care Project in Msinga sensitised members of the community on their rights and the proper channels that should be followed to compel the government to uphold citizens' rights, address matters of inequity as well as conform to international rights and standards to which South Africa is a signatory. It is noted that South Africa is a member of the UN and the African Union and has ratified many UN human rights conventions thus binding it to adhere to the standards laid down in these conventions (Kalyani 2016). Community members, together with other stakeholders and service providers, discussed the way forward in responding to all forms of GBV.

Cynthia (a community care worker who also participated in those meetings):

> "*During the sensitisation meetings, members of the Msinga community were sensitised concerning individual human rights particularly about women. Matters relating to how victims of intimate partner violence were being handled at the community pertained predominantly to the prevailing cultural norms and beliefs. One of the cultural norms held in this community is that a woman needs to be submissive all the times and treat marriages issues as private matters. Following such drive of women abuse in the community, members of the community and stakeholders involved in dealing with matters of violence were sensitised on the importance of offering adequate psychosocial support to this category of women*."

Following the ecological approach, Lori (1998) argued that the cultural, social and gender norms of a community often make it problematic for a victim to receive support and recompense. Thus, to effectively intervene in matters of IPV and to provide appropriate support

to victims, the socio-cultural environment in which offences are committed must be reflected. The subordination of women to men in many societies is a result of the generational gender stereotypes embedded in these societies.

Nokwanda from the Sinozwelo Resource Centre:

> "*The victim's level of the healing is determined by all her relationships and experiences including the attitudes and beliefs of the community. Open talks concerning IPV diminishes the shame associated with it and, in so doing, encourages victims to seek further support*."

Community members were also sensitised through home visits conducted by the counsellors, social auxiliary workers and social workers. On some occasions where family members such as children had witnessed violence and openly spoke about it, the staff from the Sinozwelo Resource Centre and the Khayelisha Care Project provided them with information on where they could seek psychological support. As mentioned in the previous chapter, witnessing violence, especially by children, can be traumatic. That is why children who witness IPV also need to be supported in dealing with the trauma experienced.

Beatrice, a social worker at the Khayelisha Care Centre:

> "*Some of the children were witnesses of the physical abuse episodes and had been traumatised too. Nevertheless, many were terrified to speak out as a result of distress and shame that in most cases accompanies such disclosure. Other clients did not know where to seek assistance as well. Even though we did provide them with psychosocial support to a certain extent, we also offered them with the necessary information on where they could seek further support to deal with the trauma they had experienced and also to calm their fears. We also educated and sensitised them on how best to interact with children who were direct victims of IPV*."

This sensitisation is crucial as IPV can break down a family. As previously mentioned, most women found themselves stigmatised and discriminated against not only by their family members but by the community at large. As argued by Josse (2010), traditional beliefs and biases are used to validate women survivors' state of deprivation in the eyes of the community.

The Khayelisha Care Project found that as a result of the prevailing cultural beliefs within the community, most women survivors of IPV experienced a negative reaction from their family members whereas for a few, it was the opposite. The counsellors, social auxiliary workers and social workers on occasion had the opportunity to sensitise and educate members of the victims' families on the significance of offering on-going support to the already psychosocially distressed women. In terms of the socio-ecological model of intervention, microsystem factors such as poor support from the community, family and associates make it hard for IPV victims to recover.

Thembelihle, a community worker, stated that the purpose of sensitisation exercises is to promote positive interactions between the women survivors and others in their immediate setting and these were, in the main, close family members. A woman survivor who participated in the study pointed to the importance of her family members being sensitised:

> "*The social worker educated my mother and sisters about the issues of IPV during her home visits. Consequently, to that, I received enormous support from my family. Probably, had she not unceasingly engaged them as well, my story would have been different. Maybe, I would have died already*."– Zamile.

5.2.1.2 Grassroots campaigning

Heise (2011) argued that the most commonly funded strategies to combat violence in low- and middle-income countries are awareness and advocacy campaigns.

Thembelihle:

> "*We are mostly funded to do small campaigns and after that, we need strategies on how we going to continue providing support. Remember we cannot open wounds and just leave them like that*."

The study findings revealed that the NGOs in Msinga have been conducting IPV awareness campaigns. These campaigns were well implemented; however, each NGO would do its standalone campaign without involving all the role players offering IPV services.

Sane, a social worker at uMusa woMsinga:

> "*In as much as we were attending these working groups like VEP meetings but we never had concrete support for each other. Each organisation would host its event and you would invite other stakeholders but they would not pitch up for support, especially if your organisation is known that it cannot provide freebies and refreshments to the guests and attendees*."

A study conducted by the WHO (2007) concurs with these findings noting that many past interventions have been ad hoc, short-term and small-scale, often taking the form of standalone awareness campaigns. As a result, these campaigns which were intended to create a platform for local advocacy initiatives became less effective at shifting behaviour. Nevertheless, the NGOs in Msinga confirmed that campaigns that involve every person affected by the issue and combine communication strategies with a community mobilisation approach, hold promise in Msinga.

The Khayelisha Care Project believed that programmes such as "You Can Take Charge", "You Can Do It" and "Young Fathers" still have potential in the Msinga area. The You Can Take Charge programme was offered to young girls, the You Can Do It programme was given to parents and the Young Fathers programme was offered to young boys to prepare them to be good fathers.

Thembelihle from the Khayelisha Care Project:

> "*We have got different programmes targeting different people but all to reduce incidents of GBV particularly IPV in Msinga. We started 'You Can Take Charge', 'You Can Do It' and 'Young Fathers'. You Can Take Charge and You Can Do It programmes were mainly intended for women, reminding them that they can take charge of their lives without depending on men. We were empowering them with knowledge and information on how to do that. Small income-generating projects were started with these women to promote their independence. We also have one programme with young men and boys, they say it takes a thief to catch one. This group of young men and boys would meet monthly to discuss issues about GBV. They were using these platforms to*

try and educate other men about the importance of protecting and taking good care of the women at large."

The Khayelisha Care Project strongly believed that the above-mentioned campaigns contributed to the prevention of violence against women in the Msinga area. The Khayelisha Care Project further stated that these actions created a climate in which VAWG was not tolerated. Notwithstanding these campaigns being effective they, nonetheless, faced challenges in ensuring that men were not advantaged over women in becoming "change makers" due to their condoned controlling behaviour – controlling what women can do and say and where they can go.

These campaigns mobilise ordinary people to take a stand against violence, particularly VAWG and inspire those around them to do the same. The campaigns only started to operate in 2017 and were championed by the Khayelisha Care Project staff and volunteers. The project confirmed that after the inception of these campaigns they noted an increased number of violence cases being reported to them for intervention. Their explanation for the increase is that the more people become aware of violence the more they would speak out about it. These campaigns raise awareness and recognition of practices such as *ukuthwala* and *ukuklinya* as violent ones. The campaigns also mobilise community members to take a public stand and action on VAWG and they create a network to sustain the modification of behaviour.

5.2.1.3 Community awareness campaigns

All four interviewed organisations confirmed that the awareness campaigns were aimed at sensitising people about GBV. The campaigns had the following specific objectives:

- Determine people's awareness of what GBV is.
- Enlighten people on the forms of GBV.
- Teach people what actions to take if they are victims of GBV.
- Affect behaviour change amongst the perpetrators and victims of GBV.
- Curb the increase of GBV issues through the use of a campaign of zero leniency.

Nokwanda, (a social worker from Khayelisha Care Project):

"*People from this community never understood that IPV is no longer a private matter. When addressing them, they would be like how is that our concern. It was important for us to teach them on human rights first before getting into issues of IPV. Awareness campaigns would be mainly conducted during the 16 days of activism but we would also emphasise that the abuse happens every day, hence it was important for them to speak out for help. Us at Sinozwele Resource Centre help our clients with laying foundation about IPV and refer cases for further intervention*."

The awareness campaigns included differentiating IPV from GBV by identifying its forms and the actions to take when one is a victim of the latter.

"*Typically, the discussions also focused on factors related to root causes of gender-based violence and ways to avoid these forms of violence*." – FGD#2.

During the interviews, it was revealed by one of the woman survivors that the awareness campaigns are less effective as they do not solve the problem faced.

"*Awareness campaigns raise consciousness to those who are abused and the distribution of pamphlets in the street for people who are seeking help about the abuse do help, yes you will be aware then what after…. we need something more productive to solve the problems of IPV that we are facing*" – Cici

This citation shows that awareness campaigns are not enough – people need more services from the service providers in preventing and responding to IPV issues. Sensitisation alone in Msinga does not seem to be rescuing the women experiencing IPV.

5.2.1.4 Community conversations

LifeLine and Rape Crisis referred to participatory reflection drawing on human rights principles and which seem to play a decisive role in bringing about collective change. They argued that these conversations are more effective when they support community members to deliberate collectively on concerns and values within the community and link human rights principles to these local concerns and values. One of the concerns that all interviewed NGO

staff members felt needed to be deliberated by the Msinga community was the abduction of young girls in Msinga which, as previously discussed, is commonly known as *ukuthwala.* Numerous community conversations regarding *ukuthwala* were held in Msinga led, in particular, by the NGOs.

One of the NGO interviewees reported their approach as follows:

> "*We started by building a rapport with different communes as the project was new in the village. We made it certain that we set up a range of community development projects to meet practical needs, such as crisis centre and income-generating projects. After we had gained the communes' trust, we then provided space for reflection through 'community conversations', where whole communities came together to deliberate their concerns and values. It was a long process but I can tell you it was worth it*." – FGD#2.

What emerged from the focus group discussion was that NGOs do not solely focus on IPV issues as a standalone issue but also difficult human rights concepts. Doing so enables conversations to flow and they are able to address local circumstances and concerns identified through these conversations. NGOs gave examples of participants pinpointing concrete challenges in their daily lives and communities during these conversations.

Sane:

> "*The spirit of sisterhood is established during these conversations, you would hear one say,* '*Some of our fellow sisters are victims of intimate partner violence' and to come up with concrete actions, you would also hear others saying,* '*We need a committee that can strongly safeguard survivors of intimate partner violence and mediate when necessary to combat IPV in Msinga*."

To relate this to human rights in terms of "everyone has the right to be free from violence", LifeLine and Rape Crisis trained young men and women to become community ambassadors to motivate their peers to take action in reducing IPV in Msinga. Community conversations drawing on human rights principles appear to play a vital role in bringing about collective change.

Du, a counsellor from LifeLine and Rape Crisis:

> "*We have recruited young girls and boys and educated them to become community ambassadors. They were trained to lead community conversations regarding GBV issues including IPV issues. They, themselves, were mostly victims of GBV. So, before they were trained on the GBV course, they went through a personal growth course where they got a platform to deal with their issues first before attempting to help others*."

5.2.1.5 Action orientated dialogues

According to Ntombifuthi, (a counsellor from LifeLine and Rape Crisis), LifeLine and Rape Crisis has implemented a GBV programme in Msinga over many years, especially supporting the crisis centre services in the COSH.

Ntombifuthi:

> "*Providing only reactive services was not enough in a traditional community like Msinga, where harmful traditional practices like ukuthwala (abduction of women and girls) are very rife and common. An integrated approach to engage and address such twisted cultural practices was very much needed in this community*."

LifeLine and Rape Crisis was thrilled when the Joint Gender Fund granted them with funding for two years to provide proactive services aimed at addressing "twisted" cultural practices and identifying the root causes of GBV. Having proactive services linked to the work LifeLine staff members are doing at the crisis centre proved to be of great benefit to the community.

> "*The action-oriented community dialogues are facilitated by ten stipend-paid ambassadors in Msinga and one year, they conducted eighty-one dialogue sessions reaching over 5 000 people*." – FGD#2.

Lifeline and Rape Crisis indicated that the programme has gained a lot of support from political and traditional leadership which is encouraging as GBV is a very difficult topic to address in deep rural areas like Msinga. Ntombifuthi pointed out that the ambassadors encourage actions

to address GBV root causes, including having a full traditional council meeting to discuss the root causes as identified by dialogue participants.

> "*The action-oriented dialogue was done in 2015 and it was quite encouraging to see the leaders taking full responsibility for encouraging men not to resort to violence in their families*." – FGD#2.

FGD#2 revealed that these action-orientated dialogues reminded the community of their responsibility to look after their members, informed the community of the challenges associated with GBV and encouraged the community to challenge twisted cultural practices. They also encouraged men to participate in activities aimed at addressing GBV in the area. The NGO participants in the FGD#2 pointed out that through the dialogues a need was identified to place the ambassadors at the local police station to ensure that victims of GBV accessed the services initially offered at the COSH crisis centre and subsequently at the Pomeroy Community Health Centre. Permission to do so was granted from the SAPS Head Office in Dundee. Currently, ambassadors are working at the police station seven days a week. However, the violence in Msinga, particularly IPV, remains high.

The women survivor participants felt that action-orientated dialogues are more effective than other interventions in addressing issues of IPV in most communities. As pointed out by one of the participants:

> "*I personally think community dialogues are more effective than awareness campaigns merely because they make everyone feel comfortable about sharing their stories and mostly, they are comprised of smaller groups and usually are cohorts*." – Tholakele.

5.2.1.6 *Imbizo*

The four NGOs were involved in working with men in Msinga to help and encourage other men, particularly the perpetrators, to change their violent behaviour. They believed that "it takes a thief to catch a thief."

Beatrice:

"*During the Imbizo, boys and men are targeted as a preventative strategy to challenge intimate partner violence and change their mind-sets towards women*."

According to Flood (2001), masculinity refers to the meanings attributed to being male in a particular context or society and includes the social organisation of men's lives. Maisel (2000) concurs with Flood stating that masculinity refers to how individuals who are gendered as male behave following a particular set of ideas about what men believe. Flood (2001) further stressed the point that violence by men is a social and cultural fact based on notions of masculinity and acceptable male behaviour. Thus, it has to be recognised that it is patriarchy that renders women subordinate to men and perpetuates male power which results in the male practice of IPV against women. Flood (1997) argued that domestic violence can only be eliminated through major changes in notions of gender, particularly notions of masculinity and societal gendered power relations. "Ideas of masculinity are directly linked to violence and power, and men's violent behaviour maintains and perpetuates male power and control over women" (GAP Discussion Document 2003:12). It was for these reasons that the four NGOs in Msinga work with men to change their mind-sets towards women and to eradicate IPV. As Flood (2001:3) claimed, "If men do not change, then gender justice is simply impossible."

During the FGD#2, it was revealed that specific attention was given to young men to help ensure that their socialisation would not involve the masculinity that undervalues women. The goal was to sensitise and raise men's awareness on issues of gender equity, power and GBV in an attempt to challenge and transform patriarchal attitudes, values and behaviour.

Sane:

"*In all honesty, it is very hard to change a man's mindset. It takes a lot of dedication to do so particularly if you are a female trying to change a man's perception. I remember the very first meeting we called, we only had two men who came to attend and the rest were women. Other men were not even interested in knowing the purpose of the meeting. They would even verbalise that they cannot sit in meetings with women and worse chaired by them. We then changed the strategy and convinced the chief of Abathembu to call imbizo on our behalf, even though he was also reluctant to do so as he did not want to be seen as a shaky or foolish chief. On the first meeting called by the*

chief, the house was full and when we started challenging some cultural norms, we then became unpopular to other men and we lost some attendance through that."

Thembelihle:

"*You are right Sane and it was for that reason we convened our meetings with younger men, who were still willing to learn. Even though you could see that these young men were socialised in the manner of promoting cultural norms. Some would show their stubbornness in such meetings and some would be willing to try for the better*."

The above excerpts show that the NGOs worked hard in trying to modify the unacceptable behaviour of men in Msinga and were having mixed success in doing so.

5.2.1.7 Engaging men and boys

Over the past two decades, there has been growing interest in IPV prevention programmes to engage men and boys in addressing men's violent behaviour and for them to make changes in their personal and interpersonal relationships. The primary focus has been on modifying the attitudes and behaviour of individual men through educational initiatives that give men information, skills and space to better comprehend how gender shapes their own lives and relationships. Less attention has been paid to recruiting men as allies in women's rights advocacy and to ensuring their accountability for VAWG. However, there are interesting efforts to take work with men in this direction. The Khayelisha Care Project pointed out that they have been working with men and boys in trying to prevent IPV in Msinga. One such initiative was the aforementioned "Young Fathers" programme which engaged with young men on gender equality.

Thembelihle:

"*The approach we used in employing this programme was using a small-group format and a no-words cartoon video. The Young Fathers programme encouraged boys and young men to question traditional views of what it means to be a man. Well trained facilitators and ambassadors served as mentors and took participants through a*

participatory curriculum. Group education was executed through regular sessions over four to six months."

It was further reported that this approach was combined with advocacy and lifestyle social marketing aimed at changing community norms. The project believed that this approach contrasted with other prevention efforts that sought to reduce the harmful consequences of an act of violence after it had occurred and to prevent further acts of violence from occurring once the violence had been identified.

Even though there has been an increase in the number of programmes in Msinga to prevent and respond to IPV, particularly sexual VAWG, there remains a general lack of evidence regarding the effectiveness of these efforts in preventing the diverse forms of IPV. Historically, most primary prevention programmes targeted women with an emphasis on improving their self-protective behaviour. Recent IPV primary prevention programmes have been accompanied by a shift towards engaging men in preventing violence against women, based on the knowledge that, in most instances, men are the primary perpetrators of violence against women, that male socialisation is a key determinant of violence, and that men want to hear from other men. Contemporary primary prevention approaches have a greater focus on preventing the perpetration of violence, with interventions delivered through settings particularly relevant to men. In addition, they encourage non-violent men to commit to serving as positive role models and recognise that men are also beneficiaries of prevention efforts. These efforts directed at ending violence are showing more positive results, especially in rural areas as men in areas like Msinga prefer to hear from other men. However, there is still a need for women to be included in these efforts as we do not wish to portray the wrong message to men that women cannot fight their battles. That alone could condone issues of IPV.

There are indeed heartening results from interventions aimed at building men's skills as active individuals and using their status as role models to intervene or prevent IPV against women in Msinga. These interventions include teaching bystanders how to intervene in situations that involve GBV including IPV and are a step towards building a broader community approach to the prevention of both. Some evaluations have found a noteworthy uptake of pro-social bystander behaviour by both women and men and which has been maintained for significant periods after the intervention training (Banyard 2007).

The primary prevention activities with women continue to be essential to effective interventions. These interventions might focus on education, empowerment, developing self-respect and self-esteem, or reducing social isolation. Shifts in women's perceptions of and responses to IPV are critical levers for attaining and sustaining changes in attitudes and behaviour among men.

5.2.1.8 Schools and life skills programmes

Primary and secondary schools are seen as major entry points for educational group programmes intended at modifying societal living standards concerning to violence and increasing girls' self-resilience and efficacy. A few organisations in Msinga such as the Khayelisha Care Project are reaching many children around the Msinga area in this regard. These educational programmes are already being employed as part of in-school life skills and sexual education classes. In sub-Saharan Africa, the gender lens has often been brought in together with the HIV lens (Cornman & Spratt 2011). This approach seems to show the most promise as few robust experimental studies exist on the "whole-school approach".

Thembelihle:

> "*We have facilitators that provide life skills and sexual reproductive health and rights programmes in some few schools here in Msinga. This programme also touches on gender norms and post-violence care. We believe this programme is implemented effectively because we get cases of abuse from these schools to attend to. Even the teachers do give us positive feedback during our feedback meetings with them that since we arrived in their schools there has been a huge difference in the lives of their school children*."

Staff from the Khayelisha Care Project spoke highly of the schools and life skills programme mentioning that it is informed by an evidence-based curriculum when delivering the sessions to the learners. However, the programme did not focus on IPV per se but promoted positive relationship behaviours and effective conflict resolution to improve relationship satisfaction and inhibit negative relationship outcomes. My concern would be to ask "What evidence are they referring to and from which area or country?" While it is good to share best practices, there is also a need to be relevant. People may be exposed to a similar situation but not respond

in the same manner and this means we cannot use an umbrella approach in responding to people's needs. The interventions employed in schools did not have a legal or judicial component focusing on the legal aspects of IPV and the negative consequences for victims and perpetrators. Moreover, subsequent analyses revealed that the outcomes of the interventions applied to girls and not boys.

5.2.1.9 Poverty alleviation programmes: cash transfers

Violence prevents women from contributing to and benefiting from development by restricting their choices and limiting their ability to act. The resulting consequences for economic growth and poverty reduction should be of central concern to governments (Murphy 2006). LifeLine and Rape Crisis and the Sinozwelo Resource Centre stated that they assisted the Msinga community, particularly women, with cash transfer programmes. Cash transfer programmes were estimated to be reaching between 750 million and 1 billion people globally (UK Department for International Development 2011). A modification was made to these programmes to optimise their impact on VAWG. The Sinozwelo Resource Centre had plans for providing small grants to those marginal women that were victims of GBV and those with the lowest gender-equitable norms as the effect of violence is most significant amongst those women (Hidrobo 2014).

Nokwanda:

> "*We had a donor-funded project where we were awarding women who had plans to start their own businesses, but that project could not last long as most women who were awarded capital could not do productive work*."

Thembelihle:

> "*We assisted a lot of clients with applying for different social grants particularly child support grants when they were still waiting for their applications to be approved, we would give them some cash to keep them going. At times we would give them some food vouchers. However, we could not continue with that as we ran out of funds. This was so sad as most women gained their confidence through this assistance."*

It became apparent that women in Msinga needed the cash transfer programme even though it was of short duration. A mentorship programme for the women who had received a cash transfer was also meant to be prioritised. The transferring of business skills and knowledge among women during the mentorship would have increased sustainability and the growth chances of the women's businesses.

5.2.1.10 16 Days of activism against gender-based violence

The 16 Days of Activism Campaign which is held from 25 November to 10 December every year is effectively implemented in Msinga and mostly targets people in their homes. However, the four organisations acknowledged that the success of this campaign rests on their daily individual and collective actions to safeguard their society against the cycle of abuse as incidents of abuse happen daily. The role of these organisations during the campaign includes the promotion of human dignity, equality, non-discrimination, non-sexism and the supremacy of the Constitution.

Ntombifuthi:

> "*Every 16 Days of Activism Campaign we make sure that we help people who are still victims of violence to come up for assistance. We would host events targeting hotspots and high-volume sites. It is part of our work to ensure that every victim of violence rather becomes a survivor. We allow them to speak in one voice*."

5.2.1.11 Training of traditional leadership

In many countries, women are more likely to approach a community leader than a government official when they have a grievance (UN Women 2011).
Supporting this contention, a woman survivor reported:

> "*The first time I noticed that my partner was abusing me, I ran to our chief and reported the matter*." – Duduzile.

However, it has been noted that communal leaders resolve disputes according to local customs and, in doing so, seldom protect women's interests. At the same time, as "custodians of

culture", customary (traditional) leaders have the power to change customs and traditions to uphold women's rights and can be significant allies (Koelble 2011). LifeLine and Rape Crisis had initiated constructive dialogues with customary leaders on women's rights. The organisation has a programme that works with chiefs, *izinduna* and village heads to re-examine and eliminate customs that discriminate against women at all levels. Issues they target and fight against include the abduction of young girls, early marriage, rape and trafficking. In its approach, the organisation provides gender sensitisation and human rights training workshops for chiefs and village heads in the Msinga area. Peer-to-peer exchanges have been conducted between traditional leaders from Msinga to build commitment and share the best learning. Efforts are underway to ensure the sustainability of this work by partnering with other local NGOs in Msinga and surrounds.

Ntombifuthi:

> "*Traditional leaders are hard to work with, they are hard to convince. One needs to know her or his story when addressing them and be prepared that you might not win their hearts. We train them in issues of violence that are perpetrated under the pretence of culture and love. We also use these leaders as our reference group when handling issues of women abuse as most of them are senior citizens with a high level of wisdom*."

Using traditional leaders in tackling IPV in Msinga can be beneficial as the role of indigenous leadership is recognised in section 212 of the Constitution, which states that: "traditional authority that observes a system of customary law may function subject to any applicable legislation and customs, which includes amendments to, or repeal of, that legislation or those customs. In terms of the legislation, it is significant that institutions of traditional leadership among everything they promote progressively advance gender equality within the institutions of traditional leadership; promote freedom, human dignity and the achievement of equality and non-sexism; promote nation-building and harmony and peace amongst people; and most important promote an efficient, effective and fair dispute-resolution system, and a fair system of administration of justice" (Rugege 2003).

5.2.1.12 Strengthening community support networks

It was noted with concern that there are only a few services in Msinga which meet the immediate medical and psychosocial needs of survivors of violence. However, according to Thembelihle, the reality is that most survivors of violence never use these services.

Thembelihle:

> "*…those who do seek support turn to informal networks (immediate family or close friends) as opposed to seeking from the formal services*."

It is critical that informal support networks are strengthened and this would include equipping people in the community to respond appropriately to disclosures of violence and in doing so meet the needs of the women survivors.

LifeLine and Rape Crisis was fortunate to receive a Criminal Assets Recovery Account (CARA) Project funded by the National DSD. The main objective of the programme was to capacitate CBOs with the necessary skills to conduct GBV trauma debriefing and provide court support for GBV survivors in KZN. This was done through the training of 10 CSO leaders and trainers in seven districts on a standardised Victim Empowerment Programme (VEP) response and court support. The programme created job opportunities as a social worker was employed to facilitate the training. Also, the programme empowered local CSOs and communities in the seven districts to provide both prevention and victim support interventions. The programme was implemented as a joint effort by LifeLine PMB and LifeLine Zululand and a percentage of the funds was transferred to the latter for it to implement the project in its areas. At LifeLine Zululand, a social auxiliary worker was employed to work under the supervision of a social worker. Recruitment of the CSOs was done through the local DSD office databases and memoranda of understanding (MoU) were signed with all participating CBOs. The following organisations from Msinga benefited from the programme: Enhlanhleni Care Centre, World Vision South Africa, Woza Moya, Isibani Community Centre, Philanjalo Care Centre and the Vukuzithathe Senior Citizens Club. The rationale for their selection was that they were from districts which were under-serviced and where the prevalence of GBV was high.

According to Nokulunga from Lifeline and Rape Crisis, the CBOs that were mentored reported having assisted some survivors with support services and court preparations. These CBOs were not receiving any financial support and, therefore, had used their own time and resources to

bring about change and provide support for survivors (who would not have received support without their, the CBOs, intervention). At the time of reporting, 86 survivors of GBV had been supported and guided through the reporting process.

Nokulunga (Gender-based manager at LifeLine and Rape Crisis):

> "*As much as it was so emotionally draining to train these CBOs but I was so delighted to be of assistance to them. What was motivating more was that these CBOs were so committed to their voluntary work. A significant number of cases they saw successfully. I give them a credit*."

The above excerpt shows that even CBOs play a significant role in providing IPV-related services to their communities. The collaboration of all relevant stakeholders is critical in addressing issues faced by the communities they serve.

5.2.1.13 Intimate partner violence-related acts and law education

It is essential to know about the state's response to IPV violence to determine where gaps exist in IPV preventative services and support legislation (Miller 1994). It is also essential to provide information through, for example, seminars on the legal alternatives for violated spouses and family members. LifeLine and Rape Crisis indicated that women survivors of IPV needed to continue organising themselves to have leadership that is inclusive of women. They also needed to partake in and/or lobby decision-making bodies starting at the local level and leading to provincial and national levels. The organisation believed that by so doing, women would be informed of their current legal rights and how they could go about attaining these rights. Women need to be continually educated about their legal rights and reminded of the fact that they, as humans, have rights. According to LifeLine and Rape Crisis, they do provide legal education and support for women who are taking a leadership role in the Msinga area and they do so with the assistance of Msinga senior citizens as their reference group.

Nokulunga:

> "*At LifeLine and Rape Crisis we have a training department that provides different training in the Msinga community. Among the topics we cover, we also provide*

leadership training particularly to women who are still new in the field of leadership. We also train them on different Acts such as New Offences Act, Domestic Violence Act, the Human Trafficking Act and more. But the question that we always fail to respond to is: When are these Acts applied? These questions are triggered by the very low conviction cases in the Msinga area."

Section 205(3) of the Constitution outlines the SAPS's constitutional duties as follows: "The objects of the police service are to prevent, combat and investigate crime, to maintain public order, to protect and secure the inhabitants of the Republic and their property, and to uphold and enforce the law." It is even more important for SAPS to be well capacitated on the legislation to better deal with the cases of abuse. Likewise, victims and survivors of IPV need to be trained tirelessly on the legislation so that they would be in a position to demand their rights and be treated fairly in police stations and courts.

For primary prevention strategies to be successful, they have to be population-based using environmental and system-level strategies, policies and actions that prevent IPV from initially occurring. There need to be social, behavioural and attitudinal modifications on the part of the Msinga community. For the successful use of these strategies in Msinga, IPV service providers have to acknowledge that men and women have different experiences of violence. They have to start from an understanding of the underlying (root) causes of and contributors to IPV against women and how to prevent it, rather than just focusing on the results or symptoms of the violence.

Focus should also be put on promoting respectful, non-violent relationships by changing beliefs, attitudes, behaviour and social norms at the individual, community and societal levels, rather than simply raising awareness or providing education on the issue. This can involve an emphasis on changing attitudes towards violence by building knowledge and skills, changing behaviour to prevent the use of violence or protect against victimisation, and changing social norms and environments so they are safer for women in particular. If primary prevention is employed correctly, it will address a wide range of factors, across multiple levels and the course of life. Factors that put women at risk of the perpetration of IPV and victimisation will be reduced and factors that protect against the perpetration of IPV and victimisation will be enhanced.

All the primary prevention services should either be directed at the entire population, regardless of individual risk for perpetration or victimisation, or they should be targeted at sub-groups with a heightened risk for perpetration or victimisation, such as particular neighbourhoods, school districts, workplaces, age groups or ethnic groups. By doing so, every individual in the community would be alerted to issues of IPV and be more willing to contribute to ending such disturbing issues.

It is encouraging that the scope of primary preventive interventions in rural areas appears to be slowly extending even though much still needs to be done for these efforts to be more visible. Research and community-based services have tended to focus more on secondary and tertiary prevention, that is, studying or serving already identified IPV perpetrators (abusers) and IPV victims or survivors. For example, a systematic review of prevention and intervention programmes focused on IPV perpetration conducted by the Centers for Disease Control and Prevention (CDC) found twice as many published evaluations for already known perpetrators of partner violence than preventive programmes (Morrison et al 2003). There is a corresponding inconsistency, and perhaps a larger one, in community-based services in that most communities such as Msinga have shelters for abused women and counselling services for both victims and perpetrators of IPV but comparatively few programmes offering preventive services. Even when community mobilisation occurs, targeted people would be those who have been exposed or have the potential to be exposed to IPV. I believe everyone in a community with a high prevalence of IPV should be targeted in the prevention programmes to enable all of them to play different roles in the prevention and eradication of this scourge. Notwithstanding the lack of published research and community programmes, there is a clear consensus on the need for prevention programmes that would talk to the needs of the Msinga community and that rigorous evaluations of those programmes should also be prioritised. The literature is replete with papers calling for increased IPV prevention efforts and providing recommendations for prevention strategies that could be employed (Campbell et al 2009; Graffunder et al 2004; Noonan & Charles 2009; Whitaker et al 2009). A significant number of prevention programmes have been commended, and researchers have urged those in the field to consider interventions at all levels of the social ecology (Whitaker et al 2009). Regrettably, there have been far more published calls for IPV prevention programmes and recommendations as to how to accomplish them than published evaluations of IPV prevention efforts.

Looking at the efforts made by the NGOs thus far in contributing to primary prevention programmes for IPV in Msinga, they show that while a lot has been tried and tested, buy-in from others sectors is still needed. Until input from all the relevant stakeholders and structures is achieved, primary prevention programmes will have limited success.

5.2.2 Effectiveness of community mobilisation

Community mobilisation is a potential strategy for decreasing IPV perpetration by men. However, this has hardly ever been scrutinised internationally. Community mobilisation was employed with great commitment in Msinga but a lack of local support was a challenge in its accomplishment. The context of a rural settlement (characterised by poor infrastructure, low education, social marginalisation and high levels of violence) severely limited intervention delivery, as did lack of institutional support for staff and activist volunteers. In Msinga, the employment of community mobilisation was done, as mentioned above, with commitment but the results show that the interventions failed to measurably reduce men's IPV perpetration. Implementing community mobilisation to reduce IPV in resource-constrained settings may require extra funds and infrastructural, organisational, political and traditional buy-in to effectively and efficiently engage community members. This will be further illustrated in the following sections.

The NGOs working in the field of IPV have increasingly begun to recognise that violence is a preventable behaviour, with new programmes being promising in terms of reducing women's experience of IPV (Ellsberg et al 2015). Nevertheless, men's perpetration of IPV has lagged with regard to empirical evidence, both in terms of a lack of studies evaluating prevention interventions among men and disappointing results from those studies that do exist. However, there are encouraging indications that awareness campaigns and group-based training among young men can decrease IPV perpetration by men (Jewkes et al 2008; Verma et al 2008) more especially if coupled with economic livelihood strengthening as in the Stepping Stones Creating Futures Program (Gibbs 2018). However, while the Safe Homes and Respect for Everyone (SHARE) trial found that the reduced victimisation reported by women was not accompanied by a similar decline in men's reports of IPV perpetration (Wagman et al 2015). The SASA! intervention in Uganda and Partnership Initiative in Cote d'Ivoire both found insignificant intervention effects on men's reported IPV perpetration (Abramsky et al 2014;

Hossain et al 2014). The SASA is a Kiswahili word which means 'now'. Of concern, is that there appear to be no confirmed programmes that effectively diminish reported IPV perpetration among known male abusers (Arango, Morton et al 2014).

Discussed below are the factors or barriers that contributed to the NGOs lack of success with community mobilisation vis a vis IPV in Msinga.

5.3 BARRIERS HINDERING THE EFFECTIVENESS OF IPV PRIMARY PREVENTION STRATEGIES IN MSINGA

Despite the legislation on domestic violence that has been passed and employed in South Africa, there is still a high prevalence of domestic violence, IPV and dating violence (WHO 2011). It is widely known that survivors of IPV often find it difficult to leave their violent partners for various reasons including fear of further violence and financial dependency on the violent partner. Leaving a toxic relationship can be very challenging and there are many reasons why a person stays, for example, some victims of IPV remain in abusive relationships because the abuser promises that they will change and that the abuse will not happen again. Victims believe this to be true, trusting that the violation will end and things will get better. Thus, when the perpetrator apologises for their actions, the victims often forgive them and take them back. However, after a while, the perpetrators will continue with their violent behaviour knowing very well that they will, as usual, be forgiven. This scenario emerged strongly in the interviews with the study participants.

5.3.1 Under-reporting of IPV

During the FGD#2, it became apparent that none of the formal structures that are in place to offer services to victims of IPV can do anything until the victims report incidents of violence. All the organisations interviewed were in agreement that there is significant under-reporting of IPV and this is a huge challenge in Msinga. According to Nqobile, (a care worker from Khayelisha Care Project) women in Msinga only present to the police, local civic structures or other services when the IPV becomes severe. It was also found that some women do not report IPV because they fear that their husbands might be beaten by the police.

Nqobile:

"*They know for sure that they have the right to complain to the police. But these so-called 'perpetrators' are their husband and they feel bad for them when the police beat them up. So, they do not file complaints against them to the police*."

Older women who reported incidences of IPV would only do so when the beating became intolerable. Furthermore, they did not see the beating as a violation of their rights and thus a need to seek justice. The women stated that the decision to report was almost a spontaneous one and not one that they would make after many days of thinking about it rationally. This was confirmed by one of the women participants who responded as follows:

"*Oh, that was when the water went above the head, you know. When things are too tough, we would just don't think about what happens next. It was about 11 p.m. and it was raining heavily. I do not remember what happened, I just bolted out of the house and went straight to the police station all alone. I just reported to the police, 'Look, my husband hits me every day and he almost killed me today.' Remember, I had never been to the police station before. And no one had told me I should go to the police station to report the matter. I just went there*." – Khanyisile.

5.3.2 Msinga's socio-cultural barriers

It is still regarded as a taboo to disclose IPV in Msinga. Thus, reporting IPV to external people is considered disrespectful and, moreover, divorce is considered shameful. Women in Msinga are encouraged to conform to these socio-cultural norms. However, these socio-cultural norms are disadvantageous to women as they have to face patriarchy, girl child marriages, restrictions in terms of dress, their voices not being heard, being discouraged to report IPV, divorce not being supported and the threats they face should they breach the "rules". It emerged from the discussions with the women survivors that it was preferable to have the status of "widow" rather than the status of "divorcee". These issues were reflected in the responses of the women survivors of IPV in Msinga. During the interviews two of the staff members also stated the following to support the above statements:

Beatrice:

"*Our community is still perceiving intimate partner violence as something taboo – not to be disclosed to others and treated as a private matter. And if they want to resolve that glitch, we as workers get heard if we suggest them to solve through kinship discussion first, and not to report it to the public such as the police…Henceforth, we strongly suggest not to report it legally. And if you try and enforce matters you can even get murdered*."

Ntombifuthi:

"*I had a case from COSH where I had to assist a child that was sexually abused by her own father as the natural mother was condoling it as she felt powerless to assist her girl child. The family of this man literally came to the hospital looking for me several times and I felt so unsafe even though I was always under the protection of the security guards. Remember, I am a citizen here at Msinga, anything could have happened to me in my way to or from work. I was even transferred to work in our main branch in Pietermaritzburg for about six months*".

5.3.3 Msinga's socio-economic barrier

It was discovered during the FGD#2 that most women in Msinga live in poverty experiencing, among other hardships, poor familial finance management, hunger and joblessness. Poverty forces women to stay in an abusive relationship. Men are said to be the breadwinners of the family with the result that whatever they say goes. Sane stated that she once had a case of a woman who was in a toxic relationship but she could not move out of because she was financially dependent on her abusive partner. A woman survivor rationalised her remaining in an abusive relationship:

"…*but at least he still supports us*." – Cici.

Sane:

"*Our clients go as far as to say, if we as organisations can support them financially, they can be able to quit these toxic relationships because if they leave, they would not be able to survive, especially that they have children to care for*."

It has been noted that the Msinga Municipality is located in a very rural area of KZN and has very limited employment opportunities. This situation poses a severe challenge which needs strategic intervention on the part of the municipality. There are no major businesses or industries within the municipality and people are mainly employed either in the social sector (provincial or national government departments) or in the informal sector. The informal sector is mainly made up of subsistence farming and small/micro-enterprises such as micro-manufacturing (Baiyegunhi et al 2019)

5.3.4 High level of illiteracy in Msinga

According to the 2011 Census, 35% of the adult population in Msinga had no formal schooling, 15% had primary schooling as their highest qualification and 30% had a high school qualification (but not matric). There is a tendency for learners to drop out of school before attaining their matric with the result that only 13% of the adults had a matric or a certificate or diploma. This poor educational level and resulting illiteracy were also confirmed during the interviews with the women survivors of IPV. The NGOs identified this as one of the most pressing challenges they were facing with people from Msinga particularly women. Illiteracy and poor educational levels result in women not knowing their rights which becomes an obstacle when challenging issues such as abuse. One of the woman survivors lamented her not finishing school:

> "*Only if I had finished school, maybe I would have got a proper job. Now I have four boys and unemployed. Even if I wanted to leave but how would I take care of these boys. Boys are too demanding and I would not afford that*…" – Celimpilo.

A multi-faceted picture of poverty, illiteracy, low self-esteem and sometimes misplaced cultural values was painted by the NGOs during the focus group discussion. Undoubtedly, illiterate and poorly educated women survivors of IPV feel disempowered and helpless in responding to the violations they are faced with. This is further worsened by deep poverty, social or community-based difficulties and little or no support services from government and other stakeholders. Also highlighted was the disjuncture between the factors that might support educational achievement on the one hand, and the actual education system and prevailing rural and cultural context on the other.

As outlined below, a challenge faced by the NGOs in Msinga was not receiving financial support to operationalise the services from government departments.

5.3.5 Passiveness of the government departments

Lack of funds and support limits the quantity and/or quality of the important work the NGOs can do and this was confirmed in the FGD#2. NGOs are increasingly finding that funds and donations are insufficient to meet their current programme needs, much less to expand programme activities. With so many worthy causes that address genuine needs such as IPV competing for the attention and generosity of the public, even wealthy donors or funders lack the resources needed to fund every worthwhile effort. Also, as populations grow, so do the numbers of vulnerable groups needing assistance from these NGOs. New problems can appear, such as the Coronavirus, which demand urgent and critical attention and require considerable funding. Meanwhile, NGOs face growing costs for staff and other programme inputs, further straining their limited budgets.

Khayelisha Care Project Director:

> "*We only got a few starting funds, during the preliminary launching of this office. Within the following year from that, we got nothing except one social worker that was subsidised, and we had to endorse our own way in finding any support for our office, so we could take care of the IPV survivors. We negotiated many times about this to the structural body, but… Well, let's hope in the following year [2020] we will get it. I am so thankful to the volunteers of the organisation*." – FGD#2.

It was apparent in the discussion with the NGO staff that dependence on grants and donations could also hinder the autonomy of NGOs in choosing which programmes to assume and which would be the most effective intervention strategies to achieve programme goals.

Thembelihle:

> "*To a certain extent, all donors and funders have their own agenda, for instance, their own interpretations as to which problems are significant and the best intervention*

strategies to address these problems. We may be then obliged to follow the money and let donors dictate the scope and direction of our activities, or else receive no funds at all. As the old idiom goes, '*beggars cannot be choosers.*'"

Another identified problem is that funding and donations often carry limitations on the types of expenses that they may cover. The most common constraint is only being able to cover direct programme costs, but not the cost of support services or other overhead costs incurred by the NGO. The NGOs must contribute these costs on their own, or at least cover an increasing share of these costs over time.

Nokwanda:

"*We may have a small amount to host an awareness campaign but providing further services from there, we need to see how are we going to achieve that*."

There is a huge demand from the NGOs for local government to support local initiatives.

5.3.6 Willingness of staff but lack of resources

This challenge faced by NGOs in Msinga links in with the challenge above. It confirms that while the staff may be willing to provide IPV services in Msinga, the restrictions on resources hinder them from providing optimal services. The foremost challenge facing NGO directors is to find ways to increase their financial security without forfeiting the vision and mission of their organisations.

Dudu (Khayelisha Care Project):

"*I think the contemporary impact is not enough, since we are unable to cover all the abused women in Msinga. We also still could not protect their privacy if they stay for being admitted to our shelter due to violence. We always talk of safe space but wonder how safe are these women in this shelter as we find it even hard to afford 24-hour security. They deserve to have that specialised care and treatment. Until today, we can only perform in a very limited space…we wish we could do better…but you know*…"

5.3.7 The caseworker: "Fundamental but powerless"

The daily caseworkers in the NGOs play a fundamental role in IPV service intervention. It was revealed in one of the interviews that the daily routines of IPV prevention and service intervention in one of the NGOs were handled by only two female officers. The two officers were paid stipends by the management despite their full-time availability to the organisation. These two officers were dealing with cases of IPV from their opening (intake) to their finalisation. They would also refer IPV cases to other relevant service providers. The interviewee believed that these two officers in providing such essential IPV services needed to be highly capacitated to do so. It was felt that they sometimes handled cases following their own instincts and not the legislation. It was also mentioned that when dealing with cases of IPV, one needs a proper debriefing.

Nokwanda:

> "*All decisions related to IPV survivors, networking, and other institutional matters are in the hands of the supervisor of the volunteers who seem to be very busy with other office staff and we manage only for administrative things*."

5.3.8 The women survivors: "Inspired but lack cultural support"

The women experiencing IPV in Msinga are positioned at the intersection of two arenas, namely, the traditional authority arena and the socio-cultural arena. Their needs are essential for the service interventions and thus there is a mutual influence between the women survivors of IPV and the volunteers and NGO staff. However, the women survivors of IPV in need of services are also strongly influenced by local traditions and beliefs. As has been noted, IPV in terms of cultural norms is a very delicate issue and not to be discussed in the public sphere, which means that it is not an easy thing for the local women who are exposed to it, to reveal.

Beatrice:

> "*Typically, women come with their own parents and make a formal report, and we discuss further for exploring the follow-up for them. It must be hard for the women if*

they have to come alone, and report their own problem since this problem needs to be decided…will be inviting the husband for further counselling or what?"

Notwithstanding the existence of the anti-IPV laws and other national policies, it is apparent that women, on their own, will never access an IPV service without encouragement from significant social supporters such as family member and friends.

5.3.9 The religious and traditional leaders: "Authoritative and persuasive but imperceptible"

It was discovered during FGD#2 that religious and traditional leaders have their own ways of thinking when addressing issues of IPV, yet they have a strong influence in societies. Directed by religious interpretations, prioritising and spreading the message of the importance of "family unity" is one of the most leading norms used by religious leaders. The norm "the man as the leader and head of the family household" is another one communicated by religious leaders and is, like the first, almost unconditionally accepted in the society. A further norm extensively reinforced in this society is "a divorce is an act that incurs the wrath of God" as a woman cannot pronounce her vows and fail to stick by them. FGD#1 revealed that pastors believed that IPV should not break family unity.

Sane:

"*The leaders in this community are our key point of support, so one would not wish to be in their black books. I remember at one time where I received a case from the community to intervene to, that case also involved the induna so he demanded that I informed him with every little detail in handling the matter. He demanded that we do family mediation without involving the law. I understood it was coming from a good place even though it was not helping me as a caseworker. He even wanted us to involve a local pastor to pray over the couple, hoping that they would change*."

The NGOs mostly prefer the legal and justice system when working with IPV cases as these institutions provide them with guidance on how to handle such cases. However, it emerged from the discussions that some NGOs in Msinga find themselves being compelled to conform to some cultural norms in handling cases of IPV, particularly those cases that involve married

couples. Conforming to cultural norms is encouraged by the traditional leadership, so for the NGOs to be accepted in the community, they find themselves having to abide by the instructions given by the traditional leadership in handling any matters regarding IPV.

5.4 CONCLUSION

This chapter captured several affirmative experiences and challenges faced by the NGOs in providing primary prevention services to prevent IPV occurring in the Msinga community. Primary prevention of IPV in the Msinga community is critical, as IPV is not only a human rights violation but with its high frequency and significant associated psychosocial and physical morbidity, also a serious public social problem. IPV primary prevention strategies mainly used in Msinga were community mobilisation which included promoting community education through face-to-face programmes; grassroots campaigning; community awareness campaigns; community conversations; action-orientated dialogues; *imbizo*; engaging men and boys; schools and life-skills programmes; poverty alleviation programmes, 16 days of activism against GBV; training of traditional leadership; and strengthening community support networks and awareness of IPV-related acts and law. It was found that a community mobilisation approach to reducing women IPV in the Msinga area was feasible to deliver but was constrained by circumstantial challenges. The NGOs' interventions in Msinga had some successes in the form of marked personal growth among staff and volunteers, high visibility of the intervention in the area even by traditional leadership, and good delivery of community outreach activities to a large number of local participants. However, several implementation challenges were identified. Local advocacy did not receive institutional support and staff training on handling issues of IPV was lacking. Aspects of community mobilisation were weak, inhibited in part by insufficient resources, skills and staff and volunteers.

The integration of the interventions with existing community resources and government programmes will, if effective, foster future sustainability and scalability throughout the Msinga community. A gap observed between the socio-cultural arena and the law and policy arena needs to be bridged by either the local NGOs or the local government to avoid the two arenas addressing IPV in a contradictory manner.

CHAPTER 6

SECONDARY PREVENTION INTIMATE PARTNER VIOLENCE STRATEGIES EMPLOYED IN MSINGA AND THE EFFECTIVENESS OF THE STRATERGIES

6.1 INTRODUCTION

In chapter five, I examined the primary interventions that were put in place for the women survivors of IPV in Msinga. The focus was on the community mobilisation interventions that were initiated to improve awareness and sensitisation of IPV related issues including access to IPV services by women at a primary level. The ecological model which was used in the study to examine the intervention strategies in addressing survivors' needs identifies psychosocial support as one of the secondary support systems that women survivors of IPV need to enhance their personal wellness. This model acknowledges the relationships that exist between various systems of intervention. It states that interventions at one level are likely to bring about changes at another level. This, consequently, assisted me in determining how various intervention initiatives, particularly those concerning the provision of holistic services to IPV victims and survivors, performed. Also examined was the interaction between the NGOs and how they impacted on the effectiveness of these intervention initiatives. Barriers that hindered the effectiveness and efficiency of the initiatives were highlighted. Finally, several possible ways of strengthening IPV interventions were suggested.

IPV response mechanisms have for the most part been developed and deployed with the primary goal of strengthening the response of the police and criminal justice system, health system and the social sector to violence against women. The question of the ability of these mechanisms to support IPV prevention and response has rarely been asked and, as this study has shown, research in this area is limited. In most cases prevention is not an obvious aim of response interventions – it has been assumed to be a consequence of strengthened response mechanisms yet this has often not been recognised through research. As this study has shown, IPV interventions or programmes have often only focused on one part of a response system, for instance, training on the part of the NGOs, without reflection on the degree to which systems

support new ways of working, or whether interventions can be effective at all without scale-up and social norm change within the affected institution.

This chapter discusses the findings, presenting an overall summary of the strengths, gaps and limitations of the secondary intervention programmes employed by the organisations in addressing the needs of women experiencing IPV in Msinga. It also discusses what the barriers in the running of these intervention programmes are.

6.2 SECONDARY PREVENTION STRATEGIES

Kirk (2017) stated that secondary prevention aims to detect the issue early and prevent progression or reoccurrence of the issue. Secondary prevention provides victims with information and services thereby mitigating the consequences of exposures to violence. The focal area is to ensure that women experiencing IPV receive support, affirmation and advice about options as well as medical attention, counselling, shelter and access to justice. The global women's movement has been at the lead of advocating for the expansion and strengthening of comprehensive response mechanisms to ensure that all survivors of IPV obtain the multiple forms of support they need to recover from violence. In most areas, women's organisations have also advocated for new legislation to criminalise various forms of IPV including domestic violence and marital rape, and engaged in extensive awareness-raising work at the community level to break the silence surrounding IPV and encourage women to seek support from these response mechanisms. The results of this advocacy have been varied among areas and communities: some areas now have a fairly comprehensive legislative framework to criminalise IPV (even though in most cases, there is a significant implementation gap); some have policies in the police and justice systems, and paralegal sectors, to assist apprehension and prosecution; some have medical and nursing staff with improved awareness of IPV; and some have a wider range of counselling and support interventions to assist violated women. However, in other areas, response mechanisms are in an elementary state and an effective legal framework does not exist.

Secondary prevention strategies for victims aim to minimise the short-term harms of violence as well as the risk of re-victimisation. For perpetrators, secondary prevention can comprise strategies aimed at preventing the escalation of violent behaviour. Like other prevention strategies, it cannot be effective if it is not integrated with primary and secondary prevention

approaches. Figure 2 below depicts the DSD's draft GBV National Prevention and Early Intervention Strategy.

Figure 2: Draft GBV National Prevention and Early Intervention Strategy.
Source: Department of Social Development (2013).

A gradual shift needs to take place from the current emphasis on crisis response to a focus on prevention and early intervention.

6.2.1 Psychosocial support

Women survivors of IPV are at increased risk of mental ill-health including depression and PTSD. For violated women, seeking support from a network of people who are compassionate and sympathetic enhances their coping skills and mitigates the adverse mental health outcomes of IPV (Beeble et al 2009; Sylaska & Edwards 2014; Lakey & Cohen 2000). It was confirmed from most of the interviews conducted during the study that psychosocial support adds much value to the well-being of survivors of IPV. Psychosocial support refers to a psychological and/or social intervention and is not merely the provision of material resources. According to Patel (2017), psychological and/or counselling-based interventions are carried out in individual and group format. These forms of psychosocial intervention involve direct communication between a client and a service provider for a specified time frame. Community mobilisation intervention, which was discussed in the previous chapter, is considered a less direct form of

psychosocial intervention. Kirmeling and Calhoun (1994) argued that signs of PTSD can transpire suddenly and have been shown to persist for up to one year after abuse, particularly if left untreated. These and other forms of psychological distress were mentioned by the female survivors of IPV during the interviews. Forms included low-self-esteem, stigma, shame, terror, anger, bitterness, depression, self-injurious behaviour such as suicidal tendencies, altered self-image, sleep disorders and a distorted view of the world. Some women indicated that they had developed a fear of and hatred towards their male partners. All the interviewed women IPV survivors described their abuse experiences as very traumatising.

Psychosocial counselling has been noted to be of great importance to victims and survivors of IPV. Unfortunately, it is typically inadequate in marginalised areas because of a deficiency of resources and traditional barriers associated with psychological help (Saxena et al 2007). The benefits of counselling were pointed to by participants:

> "*Talking about your situation helps, it does not only help you but it also helps others. Counselling sessions that are provided by the organisations help you find your identity, yourself worthy and also you regain your self-esteem. They also give you other options where you can get help such as going to the police*." – Tholakele.

> "*The psychosocial support was given to me through support groups and also one-on-one counselling and I felt much better*." – Londiwe.

> "*I shared my story with a friend of mine and she suggested that I should go for counselling and then she referred me to one of the organisations that help people who are abused by their partners where I got helped psychologically*." – Zamile.

> "*Speaking out really helps, there are so many support and advice that you can get from people that you can trust*." – Duduzile.

The NGOs mentioned numerous challenges in performing their duties. These included long waiting times, inadequate infrastructure, space, resources, poor stakeholder relationships and administrative issues. The majority of these challenges stem from the lack of respect provided to them by other stakeholders, which in turn is a direct result of the failure of the client bidirectional referral to recognise and accommodate the significance of their involvement.

Nokwanda:

> "*It is so sad that we are undermined by other stakeholders, even if they know that you are a social worker by profession but if you are working for an NGO you are not well recognised. I have seen this in different departments and it is so hurting*."

Dudu:

> "*Psychosocial support is crucial for the survivors of IPV even though we sometimes find it hard to provide such as we do not have counselling rooms*."

The role of the NGOs in IPV relates primarily to psychosocial support. It is worth noting that although the NGOs have a very prominent role in IPV, the services they provided were hampered by a lack of resources. These services were also meant to be extended to the victims' family members, making the impact of limited resources on the services even more pronounced.

Beatrice:

> "*We had some of the family members who witnessed the intimate partner violence episodes and had been distressed too. However, many were reluctant to speak out as a result of terror and disgrace that in most cases accompanies such disclosure. Others did not have an idea as to where and when to seek assistance as well. Even though we did provide them psychological support to a certain extent, we also offered them with the essential information on where they could seek for further support to deal with the shock they had experienced*."

A woman survivor narrated:

> "*The social worker also spoke to my mother and sisters as I would come with them for my sessions. They were also negatively affected by the fact that my fiancé was abusing me. Whenever I had to share my story, they would cry with me. I think having them getting support from the social worker made them realised that all that was happening to me was not my fault and at times I would feel that they were judging me as they would think I was failing to be a proper makoti*." – Zamile.

What was evident is that at this level of the socio-ecological model of intervention (the exosystem level), the women had contact with NGOs during which they were able to receive psychosocial support. One weakness in the application of the model is that at this level the clients were not actively involved in designing the programmes or the kind of support that was provided to them by the NGOs or in certifying that their needs were successfully met. Bronfenbrenner (1995) confirmed that the participant at this level is passive in that she/he cannot influence the policy-making process but is still affected by the decisions made. The clients' inactive role in the decision-making process explains why one would find the NGOs complaining about women survivors not turning up for appointments regardless of whether they had stabilised psychologically or not. The strength of the model, however, lies in the fact that those women who were likely to receive an undesirable reaction from their immediate environment (the family and friends) had an opportunity to seek support at this level. As indicated in Chapter 4, one of the effects suffered by the women survivors of IPV included abandonment by their husbands' families, their own families and even by peers once they had learnt that they (the women) had been abused. The main reason behind this kind of reaction from their families was due to the stimulus of factors operating at the macrosystem level, typically the existing cultural beliefs in the community in which this research was conducted. Two such beliefs were that a woman needs to be submissive towards their male partner irrespective of the circumstances they might be faced with and marital issues were to be treated privately.

Thembelihle:

> "*We attended many of the women who had been violated by the intimate partners where we were offering trauma counselling to them. And a significant number of the survivors would rarely have finished the mandated four sessions for various reasons counting fear of being known that they were victims of IPV and or lack of transport. We observed that those that finished their sessions with us had regained their confidence and were more open with us as they continued to stabilise emotionally and physically. We also provided group counselling sessions. We used to group the survivors into various nature of their problems and age groups and that enabled them to feel free and open up and share their challenges freely. We would also make follow-ups to those who were not adhering to the counselling sessions as required but most of the follow-ups were*

unsuccessful as most victims did not pitch up for follow-ups and some did not even have mobile phones. They were also ever-changing their places of abode."

6.2.1.1 Individual face-to-face counselling

Survivors of IPV need someone who can listen. This was evident with the women survivors of IPV during their individual interviews as most of them said they felt better after someone had taken time to listen to them. Individual face-to-face counselling was offered to the Msinga IPV women survivors by a well-trained counsellor as part of initial post-trauma care to improve their coping mechanisms. Counsellors primarily employed active listening techniques, permitting the women to share their experiences. Conversations also focused on coping mechanisms and plans and considered social and familial consequences of the IPV.

Many survivors of IPV state the effects of the violence tend to be minimised once a counsellor or social worker has listened to them. Counselling in this regard aids in putting the survivors' minds at ease since survivors of IPV are often doubtful about what the counsellor will do with the information concerning their violation. It was mentioned during the FGD#2 with staff from the NGOs that in many instances if the violated women do not receive counselling, they have problems mixing with others and would prefer to isolate themselves from other people. There is a great concern that in doing so, they would depend to a greater extent on the person who was abusing them (in a situation where the abuser is the intimate partner). The NGO participants stated that counselling sessions involved discussion of emotional pain and trauma-related symptoms and parenting skills. The Khayelisha Care Project reported that after they had engaged with IPV women survivors in Msinga, they noted a large increase in the number of women reporting better relationships with their children and some women went as far as reporting an increase in social support networks. Counselling sessions were also structured to encourage women to share experiences and develop within-group support networks.

All four participating organisations confirmed that they provide counselling and therapy to improve psychosocial support and emotional well-being for the clients faced with IPV in Msinga. Counselling, therapy and psychosocial support are often used interchangeably but there are subtle differences. Jewkes (2014) describes the differences as follows:

I. Counselling usually refers to a relatively brief intervention that is focused mainly on a particular symptom or challenging condition and assists in dealing with it, typically through brief educational, cognitive-behavioural, and motivational interviewing approaches.
II. Therapeutic interventions are more intensive treatments than counselling and mainly focus on the client's thought processes and way of being in the world, rather than specific challenges.
III. Psychosocial support offers practical assistance in the form of care and support to victims or survivors of violence and may also include counselling and therapeutic intervention.

The main aim of the organisations in providing the above-mentioned interventions was to ensure that they assist their clients in improving their psychosocial well-being.

Thembelihle:

> "*We do provide face to face counselling sessions to the individuals that need such services. This role of counselling extends from managing acute distress to assist them in avoiding additional and future exposure to violence. To deliver on this role, the NGOs and DSD services have to work cooperatively and complimentarily*."

Ntombifuthi:

> "*LifeLine has been given space and roles within the Church of Scotland Hospital crisis centre where we provide counselling sessions to the victims of IPV. Most cases of IPV would be referred to us by the hospital itself for us to provide further support that the nurses cannot provide*."

Nokwanda:

> "*When one has been abused by a partner the power has been taken away from them by the abusers and consequently should know their options and decide what to do next. The survivor should be on a process of regaining their power and strength*."

The organisations that participated in the study provided psychosocial support to all victims presenting at their organisations. The majority of the cases concerned IPV including sexual abuse and physical and emotional violation. There was no consistency as to who saw the victim first but most of the respondents felt that they should be the first professional to engage the client. The psychosocial support in the organisations was offered by a mix of trained lay counsellors, social auxiliary workers and social workers. In the COSH crisis centre run by LifeLine and Rape Crisis, the medical staff also had a responsibility to counsel the victim in preparation for and during the medico-forensic examination, whilst psychosocial support in the other three organisations was provided by the organisations themselves. Trauma counselling and containment was the key service offered at the point of contact after which the clients were usually referred to other forms of psychosocial support. Some of the women participants spoke about their experiences with the individual face-to-face counselling sessions they received and one such experience is reflected below:

> "*I was so traumatised. I find it so hard to deal with it. I felt absolutely empty and broken. Talking and being counselled while at the shelter by Khayelisha Care Project assisted me. I do not really know if I had not been counselled what would have become of me [crying]. I felt so depressed at that time and I was not even able to pay much attention. I feel better now; I can encourage other women who have been through similar situations to also seek such support*." – Zamile.

6.2.1.2 Containment counselling

Containment counselling was provided by the first respondent within the psychosocial support team. This caseworker dealt with managing the crisis by calming the victim or survivor down, comforting them and assuring them of their safety. This type of counselling also involved giving the client information about the services provided by the organisations working with survivors of IPV (including the crisis centre at COSH), the processes that would be followed and their rights concerning accessing services and laying criminal charges. This was seen as an indispensable step in stabilising the client and comforting them. It was also perceived as the first step in the healing of the survivor.

Ntombifuthi:

"*Containment is all about crisis management and educating clients about how the crisis centre functions and their rights within the crisis centre*."

Thembelihle:

"*This is the most difficult part of psychosocial support where one needs to calm down the nerves and fears of the client. Making her understand that she did not make a mistake by seeking help as well as assuring her the best service. If this part did not go well, chances for progression are very slim*."

In the FGD#2, it emerged that containment counselling provides the client with the procedures that will be followed and informs them of their rights concerning accessing services and laying criminal charges should they wish to do so. This was perceived as a critical service as it was the first contact with the client.

6.2.1.3 Follow-up therapy

The NGOs mentioned that it was routine for follow-up therapy to be scheduled with the social workers, often the day after the reporting of the incident. All four organisations provided a minimum of four follow-up sessions after which others could be prescribed on an as-needed basis. The follow-up counselling was aimed at strengthening coping skills and supporting reintegration into society.

Nokulunga:

"*Most social workers and psychologists who offer therapy provide it with every step of the way. They first start by offering four mandatory sessions with the survivor and after the four sessions are over, the survivor can then choose if they would like to continue therapy or not*."

Nqobile:

"*In respects to the psychosocial part of therapy services which takes the form of three sessions. As we provide services, the client is required to attend three sessions but the client can continue to need the services during the prosecution and court phase*…"

O'Callaghan et al (2013) and Satyanarayana et al (2016) argued that cognitive behavioural therapy (CBT) is used for a variety of emotional, behavioural and psychiatric issues and helps patients to identify negative thoughts and behaviours and to replace them with healthier ones. Participants in the FGD#1 cited the social workers' advice and support playing a significant role in their recovery. No participants mentioned foreign professionals making an impact on their recovery.

6.2.1.4 Group therapy and indigenous support groups

The Khayelisha Care Project offered group therapy where similar cases were combined and a support group formed. The main focus of this approach is to share coping mechanisms and offer peer support. Offering group therapy is more easily done by the project as it has a shelter for the abused women.

"*We do group work amenities because other women cope well in a group as they are with others and for the fact that they become each other's pillar of strength. We have also found group therapy more effective as in group work, women are imparted with life skills and we speak about boundaries and self-care and safety skills*." – FGD#2.

The group counselling offered by the Khayelisha Care Project for the women survivors of IPV focused on providing psychoeducation and new skills, for example, problem-solving skills. In the FGD#1, over half of the participants mentioned that their social life had improved after the intervention, including their interactions with family members, and their stress levels had improved as well. Many participants also mentioned being happier and reported an improvement in their emotional health.

Thembelihle:

"*We also conduct support groups where the survivors can share their challenges based on the outcomes of their cases. We have learnt that some medications that they are*

prescribed to, have side effects and when they are in a group, they can share their coping mechanisms when it comes to the medication they are taking. So, our groups do not merely focus only on psychological support but we touch in almost all aspect of life."

It was noted that there are also unstructured indigenous support groups that exist in Msinga. The NGOs at times referred the women survivors to these groups as, comprising of and belonging to women, they saw them as critical, especially for the women survivors' restoration and re-integration.

Dudu:

"*We usually refer the traditional women to these groups. Through these support groups, women survivors of IPV are allowed to share their experiences and interlink with fellow women who have endured similar experiences*."

It was revealed in the FGD#2 that these groups have shown their efficacy by providing women survivors with a secure place to deliberate their experiences and obtain hands-on skills to assist them in coping with their situation. The Khayelisha Care Project was aware that as a result of the prevailing cultural beliefs within the community, some women experienced a positive reaction from the indigenous support groups whereas this was not the case for other women.

6.2.1.5 Telephonic counselling

Over and above the listed interventions, LifeLine and Rape Crisis offers IPV survivors counselling via the phone. This is reported to be a 24-hour service. According to the social worker from LifeLine and Rape Crisis, IPV survivors gain information about violence and some feel they have more support through telephonic counselling. By providing advice and support via the phone to survivors of IPV, Lifeline and Rape Crisis' contribution to the overall set of survivor support services is evident. However, some women survivor participants felt that it was sometimes hard for them to follow things through when being counselled on the phone and rather preferred counselling which was face-to-face. Telephonic counselling for them was only to be done when one felt stranded.

6.2.1.6 Community outreach services

Another psychosocial service provided by the NGOs in Msinga was community outreach services. This targeted high risk and vulnerable families and included family counselling – especially where children were involved.

Dudu:

> "*Social auxiliary workers and child and youth care workers are the ones mandated to do community outreach work through home visits. They go to the homes and communities to provide their necessary support and also educate the masses on what intimate partner violence and traumatic rape syndrome are. The home visits usually follow after one-on-one sessions in the office... If there is a need for the child to be removed, particularly if the violence happened within the family, then we work with the DSD through courts to do statutory and remove the child from that environment. We as an organisation do not do statutory and that is why we involve DSD in such matters. We ensure that the child is protected so we go to courts with them as well*."

6.2.1.7 Crisis centre at the Church of Scotland Hospital run by LifeLine and Rape Crisis

The women survivors and the NGOs that were interviewed confirmed that crisis centres provide a critical service to survivors of IPV by establishing a one-stop-shop for them to obtain medical and legal assistance and psychosocial support services. They also agreed that crisis centres are vital because they have a victim-centred approach for survivors of GBV that aims to provide compassionate support and assistance and to avoid potential secondary victimisation.

LifeLine and Rape Crisis spoke highly of the services they were providing through their One Stop Centres (OSC) that aim to offer health, police and social services in one place, allowing survivors to access essential services easily and speedily and also avoid secondary victimisation. The OSC they operated in Msinga is located in the COSH.

Ntombifuthi:

"*We are stationed at the crisis centre where we receive all cases of abuse. It makes things easier for our survivors because they can get medical care, psychologist, social worker and police in one place*."

The centre aims to assist survivors of domestic violence and rape in meeting their immediate needs. According to Thembelihle, the prevention of violence is very much a secondary objective for those services that do deal with IPV survivors. Their effect on violence prevention, over and above that of other service delivery models, was likely to be minimal.

This crisis centre provides survivors of IPV with comprehensive, multidisciplinary services that address their needs across the medical, psychosocial and legal fields. It thus provides services such as medical care, legal advice, counselling and safe housing. In addition, it frequently provides survivors with referrals to services outside the centre which are not offered by the centre.

6.2.1.8 Creating safe spaces

In Msinga, it is the women and especially younger women, that are particularly vulnerable to IPV. Their ability to move spontaneously in the community becomes constrained thereby weakening their social networks. Austrian and Ghati (2010) indicated in their research that adolescent girls are less likely than boys to have strong friendship networks, somewhere to go if they need a place to stay, and a friend to borrow money from should they require resources that can protect them if they are in danger at home. By building up their social assets, women and girls are less likely to be targets of violence and are better able to respond to safety threats and to feel safer in their communities (Amin & Anderson 2011).

Young women asset-building programmes are aimed at protecting young women who are vulnerable and at risk. These programmes were pioneered by the Terre des Homme and have been implemented by LifeLine and Rape Crisis in their work with young women. The programmes create safe spaces for young women in Msinga where they can meet regularly without fear. Youth ambassadors who act as mentors implement the curriculum, provide support and advice and act as role models for the young women. The ambassadors are themselves young women from the community with whom the young women can identify.

In those meeting platforms, VAWG is addressed at all levels and is combined with literacy training, sexual reproductive health and rights education, and developing life skills such as personal growth, interpersonal negotiation, basic financial capabilities and leadership. Evidence-based curricula such as Vhutshilo 2 and Economic Strengthening (financial capability, employability, entrepreneurship, and Support Access to Tertiary Education (SATE)) are used to allow young women to raise issues of concern to them. Most programmes last between one and three years and take place in conjunction with efforts to create safer communities by engaging with men and boys and community members, including traditional leaders.

The approach used by the NGOs is to mobilise young women and girls into groups that meet with adult female mentors or an ambassador at community halls at least twice a month. Following training, mentors or ambassadors methodically identify out-of-school girls who are eligible for the programme by going from house-to-house. Once eligible girls are found, they are invited to participate. The mentors or ambassadors would secure informed consent for participation from parents, caregivers or guardians. Should a girl be absent for three or more group meetings, mentors would visit the girl's household to establish the reason/s for her absence as the group to which she belongs is a cohort and accordingly, supports her. The programme links girls with health facilities and other services for further intervention. For example, LifeLine and Rape Crisis partnered with the Khayelisha Care Project which, as noted, is a local organisation that offers shelter and support to women and girl survivors of IPV in the Msinga area. Those women and girls would then receive face-to-face counselling, legal support as well as benefit from the friendship of others in the shelter who had gone through a similar experience. Lay counsellors and ambassadors from other local organisations also visited the Khayelisha Care Project groups to teach women and girls how to diminish their risks and to publicise their services.

Ntombifuthi:

> "*We are working with community ambassadors. They are trained to handle issues of abuse. So, what they do, they meet with women and girls in their safe spaces to help each other deal with challenges they might be faced with. Different topics are covered in their cohorts using evidence-based curriculums*."

6.2.1.9 Shelter also known as the "White Door"

The Khayelisha Care Project's shelter which is referred to as the "White Door", is used by women who have experienced severe, usually chronic and sometimes life-threatening violation. It enables the survivors of IPV to leave an abusive relationship, at least temporarily, thus preventing violence during the period the women were absent from the abusive partner. Many women have benefited from the shelter's assistance package. Thembelihle, who was from the Khayelisha Care Project, mentioned that the long-term effect of shelters depends on the women's ability to live independently after leaving and on their readiness to make changes to their own lives including leaving their partner. The project director emphasised that the shelter was offered as an isolated intervention in which women who enter them receive shelter packages which varied but usually included face-to-face counselling, information and practical assistance with accessing legal protection and autonomous living. The project's shelter only accommodates a very small proportion of abused women, hence women survivors of IPV were not encouraged to stay for too long in the shelter. It was, therefore, noted that shelter provision was unable to significantly impact on levels of IPV in the community but a relatively small number of women survivors had and were benefitting from it.

It also confirmed that the services provided by the Khayelisha Care Project shelter to victims of IPV played a critical role in the care economy but unfortunately, services provided by the care economy were under-valued and under-resourced.

Dudu:

> "*We have a shelter for women who are abused and there are several services we offer in our shelter*."

Thembelihle:

> "*In terms of the services offered to survivors of IPV, our shelter provides free accommodation; three meals a day; toiletries or comfort packs; psychosocial support; skills-development programmes; and assistance with health and legal matters such as*

accessing protection orders following up on intimate partner violence cases and assistance with divorce and maintenance issues."

The women survivors of IPV in Msinga who participated in the study pointed out that the shelter also assisted them with applying for different social grants and with applying (or reapplying) for legal documentation such as identity documents and birth certificates for their children.

The programme interventions offered by the shelter aimed at healing and restoring a sense of self and included life-skills, mindfulness interventions, and initiatives that aided the women to recover from the trauma that they had experienced. The shelter also encouraged some exercise and physical activity and programmes that sought to create an awareness of human rights and gender issues.

6.2.1.10 Women economic empowerment

Some of the NGOs had initiatives focusing on women's economic empowerment which improved women's bargaining power and their ability to leave abusive relationships. The initiatives included but were not limited to, strengthening women's entrepreneurship and employment opportunities, promoting equal sharing of unpaid care work between women and men, and motivating for universal access to an excellent education. However, because of a shortage of funding these initiatives were limited in their application. While such efforts could influence increased IPV against women survivors in the short term due to gender norms linking men to the provider role, increasing women's economic empowerment is critical for long term prevention of IPV. Women's economic empowerment programmes which also address gender norms and reach couples and communities can lessen risks of women being exposed to issues of IPV.

All four of the interviewed NGOs stated that they prioritised women when they had to employ more staff in their organisations. The women were sent for training before starting their work with the NGOs. The training that impacted positively on the lives of the Msinga women recruited to work for the NGOs was the "Personal Growth Course" offered by LifeLine and Rape Crisis. The course was said to encompass anything from leadership training and building a new skill to inspiring women to pursue a passion in and out of the workplace.

Ntombifuthi:

> "*By and large the community ambassadors we employ are women in an effort of promoting women empowerment. Because they have a lot they are dealing with, we provide them with Personal Growth Course before they even start engaging with clients for them to deal with their inner selves*."

> "*We train women on entrepreneurial skills for them to start their own businesses…*" – FGD#2.

6.2.2 Effectiveness of the psychosocial support provided in Msinga

This study provided evidence on the efficacy of structured psychosocial support interventions aimed at secondary prevention strategies of IPV to address psychological distress. The secondary prevention strategies were found to be not efficacious when provided in isolation. Also, administering these interventions alone may result in negative effects given the interrelation that has to exist between other IPV prevention programmes and mental health in the form of psychosocial support. Moreover, these findings provided information regarding the feasibility of employing a structured coordinated intervention for IPV survivors in Msinga.

Evidence on the effectiveness of efforts to prevent IPV against women in Msinga is emerging. As discussed in the previous chapter, primary prevention efforts aim to diminish the number of new occurrences of IPV by addressing risk factors for violence which commonly operate at multiple levels of the social ecology. According to Bourey et al (2015), social, economic and combined interventions have been found to successfully reduce the incidence of IPV in low- and middle-income countries (LMIC). This approach for IPV secondary prevention is also promising in Msinga. Although the findings are encouraging, the current evidence suggests that primary prevention efforts may have reasonable effects, often on a select number of outcomes under investigation. In addition to primary prevention programming, secondary prevention intervention may aid in ending violence against women who are currently in an abusive relationship; decrease the chances for future or secondary victimisation, for example, by referring women in a violent relationship to advocates who provide legal, housing and

financial advice; facilitate access to community resources; discuss safety planning; and provide ongoing support and counselling (Rivas et al 2015).

Even though generic psychosocial support (for example, generic supportive counselling) is a common element of advocacy interventions, there appears to have been little discussion regarding the contribution that more structured psychological support could make in strengthening the impact of secondary prevention interventions (Rivas et al 2015; Oram et al 2016). Tsai et al (2016), in a large longitudinal study conducted in South Africa, found that IPV was associated with depressive symptoms, which in turn increased the risk of future victimisation. My study related to this as most of the women survivors interviewed mentioned being violated more than once in their lifetime. Similarly, studies conducted by Perez and Johnson (2008) and Krause et al (2008) revealed that PTSD symptoms as a result of IPV may put women at increased continued risk of future violence. The women survivors interviewed often spoke of experiencing abuse several times, referring to it as a "curse". Psychosocial support for a bi-directional relationship was found in secondary prevention intervention with IPV survivors to have a high chance of reducing risks of future victimisation and PTSD symptoms. These serious issues notwithstanding, the findings from this study indicate a vicious cycle between IPV and psychological distress and lend support to the hypothesis that multi-component strategies may play a huge role as part of the comprehensive efforts required to reduce IPV in Msinga. Likewise, these strategies may simultaneously empower Msinga women through an advocacy component, as well as reduce psychological distress through structured psychosocial interventions.

The findings of this study suggest the NGOs played a huge role in caring for the IPV women survivors. The NGOs were available to help survivors through life challenges and that was a key to sustaining the women's mental well-being as the NGOs assisted the women to cope after experiencing a traumatic event. The interviewed women survivors were of the view that seeking support from a network of people who were supportive and sympathetic enhanced their coping skills and mitigated the adverse mental health outcomes of IPV. Authors such as Beeble et al (2009), Sylasta (2014) and Lakey (2000) are of a similar view.

The women survivors who reported negative family reactions had their mental health negatively impacted, and accessing formal services such as psychosocial support was not positively associated with their resilience. Worryingly, mental health services in the Msinga

area are limited and often not easily accessed and the value of family and NGOs support, therefore, cannot be over-emphasised. Thus, to increase women's utilisation of available services and their sustainability, there is a huge need to promote stronger psychosocial support and social networks in families and communities. Support groups appeared to be the platforms through which women networked with other abused women and which provided them opportunities to attain instrumental support that could assist them to cope better as well as foster their self-efficacy and esteem (Williams & Mickelson 2004). Capacity-building for the Msinga NGOs to deliver effective and efficient psychosocial support within the reach of women was also identified as a critical issue that needed to be responded to.

Several limitations need to be taken into account when examining the potential impact of psychosocial support under secondary prevention strategies. These are outlined and discussed below.

6.2.3 Barriers hindering the effectiveness of psychosocial support in Msinga

Through the interviews with the women survivors of IPV in Msinga, it was found that the intervention programmes have been effective at increasing support for survivors and access to services. However, several of the programmes are fairly new and challenges include a lack of awareness about the available services, limited capacity of services (for example, safe places, courts) and their minimal reach in rural areas, weak response of law enforcement to IPV, and limited economic opportunities for survivors leaving their partners. A major challenge was that most government departments did not put the clients' interests first, suggesting that better training is needed. In terms of the police response to IPV in Msinga, various challenges emerged including a culture of male dominance in the police force, the need for further training on how to provide supportive, non-judgemental services to survivors, as well as the need for improvements in procedures and the timeliness of responses. A significant majority (80%) of the participants reported not being satisfied with the SAPS' sense of urgency in addressing GBV. As a consequence, participants did not feel confident about security measures in the Msinga area. Nokulunga stated that numerous occurrences of GBV have gone under-reported because of Msinga residents' lack of confidence in the SAPS. While the central focus must be on victims, another area of focus involves those who are directly involved in responding to partner abuse cases in the Msinga area. Below are further barriers mentioned during the

individual interviews with both the NGO staff members and women IPV survivors and the focus group discussions.

6.2.3.1 Fragmented and ineffective programmes

In the FGD#2, it was pointed out that the programmes combatting IPV are fragmented and not adequately resourced. Some NGOs felt that without a common agenda around IPV, the programmes would remain weak, poorly coordinated and have little impact. Because the programmes are perceived as ineffective, there is hopelessness within the Msinga community in general.

Thembelihle:

> "*I would confidently say that we need a strategy … for the next coming years that would address violence against women here in Msinga, and this is how we are going to monitor the strategy and this is budget and this is how we are going to employ the strategy. We, together with government institutions, should continuously monitor this strategy and its efficiency. Whatever is not working out should be relooked. Having no funding to address violence against women simply shows that this issue is not taken seriously as it should by government and NGOs*."

6.2.3.2 Shielding of perpetrators

The shielding or defending of the perpetrators by the victims of IPV and their in-laws emerged as a significant barrier. Participants in the FGD#2 commonly cited reasons for victims not accessing services such as the interference of family in-laws. In such instances, families opted to resolve the matter internally to avoid possible criminal prosecution of the perpetrator as he was, apart from being family, also the women victim's partner. This course of action was particularly evident in situations where the male partner was a breadwinner in the household.

Dudu:

> "*Women victims of intimate partner violence become reluctant to report cases of this nature simply because the victims they want to protect the abuser who is a provider*…"

Nokwanda:

> "*We know that they are being abused but they do not want to be helped at times because they know that might result in having their partners arrested and we cannot force them to seek for help*."

6.2.3.3 Logistical problems

All four interviewed NGOs referred to logistical problems experienced by the clients when accessing care at the different service providers. Even though most agreed that the location of their organisations meant that the route was well serviced by public transport, they still believed that the cost of transport to the organisations was unaffordable, especially for the unemployed women. Access for persons living with a disability was also mentioned as a challenge.

Dudu:

> "*There is a problem regarding transport as transport is very expensive and remember our clients are mostly not working*."

Thembelihle:

> "*We have been trying to address this but with failure, our setups are not accessible to people who are living with disabilities*."

Nokwanda:

> "*At times I fail to understand why a department like SAPS, for instance, do not offer transport to survivors of intimate partner violence because at least with them, they do have enough transport unlike us*."

6.2.3.4 Long waiting times

Even though the NGOs indicated that the psychosocial services were always provided, they mentioned that sometimes clients had to wait a long time to be served and this was due to various reasons. Reasons included staff inaccessibility and also limited counselling rooms to offer the services concurrently. This was potentially dangerous in cases where clients presented with suicidal thoughts.

Sane:

> "*You will not believe this; we only have one room for a counselling session and most definitely that leads to survivors waiting a long time to see a social worker*."

Nqobile:

> "*…survivors for them to access the services they have to stay there for hours and hours just waiting for one social worker to finish with others and remember we would not even have something to offer like food and some of our clients are diabetic*."

Beatrice:

> "*It is worse for us because we have the turn-around time for clients… they sit a long time on the benches waiting to be served. The rule for us is that one should wait from 45 mins to an hour but we are going overboard … you find there is a survivor that has arrived in the morning and only attended to in the afternoon and that merely shows that issues of the survivors are not being prioritised*."

Nokwanda:

> "*We would sometimes resort to having some clients seen by lay counsellors who would later refer to social workers for further intervention and this alone counts as secondary victimisation as the client would have to retell and retell her story to different people*."

What emerges from the excerpts above is that some social workers are overworked and have multiple cases at any one time. As a result, the victims have to wait long hours before getting any help.

6.2.3.5 Fatigue of the NGO staff

All the NGOs interviewed mentioned that in most cases they feel very tired, weary or sleepy and they think that this is a result of prolonged mental and physical work, extended periods of anxiety, exposure to the harsh environment and loss of sleep. According to Sadeghniiat-Haghighi and Yazdi (2015:12), "Fatigue is a result of prolonged mental or physical exertion; it can affect people's performance and impair their mental alertness, which leads to dangerous errors." This is concerning because fatigued people have poor communication with the surrounding environment and are quicker to become angry with other people. Consequently, a fatigued worker is potentially dangerous to themselves and others, and the highest rate of problematic incidents is usually found among fatigued caseworkers.

> "*The most critical impacts of fatigue include decreased task motivation, longer reaction time, reduction of alertness, lessened concentration, poorer psychometric coordination, problems in memory and information processing, and poor judgment so how are you expected to handle such critical cases in that state of mind*." – FGD#2.

6.2.3.6 Insufficient working space and other infrastructure

Lifeline and Rape Crisis complained about the inequitable allocation of working space. Since the crisis centre is in the COSH, the allocation of space is done by the DoH staff. The NGO complained that they were intentionally side-lined in the allocation of space, consistent with the allegation that they (the DoH) viewed their services as marginal. The NGO also conveyed how the absence of space compromised clients' confidentiality as they had to pack files in a small unsecured space with no controlled access.

Ntombifuthi:

> "*I feel there was an inequitable distribution of space in this crisis centre. Clinical staff are given priority when it comes to space. At times we would be forced to attend our clients in the presence of a nurse, then breaching terms of confidentiality ... "…over and above that we are not are not permitted to use hospital phones and not even using the hospital photocopy machines but they always tell us that we are helping each other*."

Du:

> "*… counselling rooms are not sufficient and of course the entire container is too hot in summer when temperatures are sitting at higher degrees and you go into that container it is so hot you can't even breathe*."

Nokwanda:

> "*Office space is also challenging for us… the space is very small and offices are shared among the staff members*…"

Nokulunga:

> "*If we deal with such cases, we definitely need privacy. I need to supervise volunteers and students, I need to do counselling but our office space comes with a lot of disruptions and interruptions. We are all struggling indeed*."

6.2.3.7 Insufficient resources

All four NGOs complained about insufficient funding affecting their programmes' ability to deliver optimal services. The lack of resources predominantly impacted staffing and thus the ability of the NGOs to provide a high-quality service. Most NGOs functioned with volunteers and sometimes students. In many instances, cases could not be followed up in the community for counselling and support due to a lack of funding. Thus, many cases, while being offered trauma counselling, had unsatisfactory follow-up therapy which is identified as crucial especially for those cases that end up in a court hearing. Excerpts from the FGD#2 illustrate the extent of the problem:

> "*The coverage issue is also one big problem as we are not open 24/7. We are not sufficiently staffed. We then have to work overtime making certain that every case file is in order and that we make follow up visits to families, making phone calls for follow up counselling sessions and if you feel that a client is at risk you have to make home visits and make risk assessments and advise the client to follow safety plan*." – FGD#2.

"*You need at least four people to have a nice shift and by that, we would have time to write our reports and actually take breaks because what we are currently doing it is one person after another right through which is not healthy as we are dealing with very traumatic work*." – FGD#2.

"*The funding that is there is to make sure that the survivor heals properly after the exposure to intimate partner violence. Other things like getting medical care are not covered, people do not realise that there is actually more to it and I don't think our funders are prioritising it. The plan on how we could support the victims of IPV post-exposure maybe for a year or so until they become emotionally strong again is not clearly discussed by our directors. And I strongly believe it will have a lot of positive impact on how they are living their lives thereafter if they were not abundantly supported and they were not actually emotionally well they would not heal completely*." – FGD#2.

Nokwanda:

"*Even when it is time for us to request for leave, we find it almost impossible to get leave. We are indeed short-staffed and of course, we need more*."

Insufficient resources also obstructed the care offered to the staff members themselves. Three NGOs could not meet the expense of debriefing services for their staff who dealt with very traumatic cases on an on-going basis.

6.2.3.8 Unhealthy working relationships with other stakeholders

All four NGOs felt that the IPV cases could have been better managed had good working relationships and better referral and improved client care with other service providers being in place. It was apparent that the NGOs' relationships with other stakeholders were often a bottleneck and barrier to realising the smooth running of their services. The NGOs believed that they were being undermined and the services offered by them were looked down upon. They complained that they were not perceived as partners and were made to feel as if their

services were not significant to the clients. Sometimes they were made to feel they were not professionals.

> "*I think we should learn to appreciate and respect each other. No one should feel inferior or vice versa over one another often we are treated unfairly*." – FGD#2.

Nokwanda:

> "*The DSD social workers feel that they run the show even though you are both social workers*."

Two NGOs complained about their relationship with the DSD and the SAPS. They said that the DSD micromanaged their staff and the SAPS undermined them and even threatened to send destructive reports about them to their funders. The DSD required to know who was funding them and for how much, and interrogated some of their decisions to hire or not hire staff. The NGOs also accused the DSD of bullying their staff into sending them their monthly reports.

6.2.3.9 Absence of accountability

Three NGOs stated that there was little accountability in their organisations as there was a lack of supervision – the members of staff were accountable only to themselves.

> "*We take cases and nobody holds us accountable and for me, that is a gap because we should have some levels of accountability in what can be done if one of us is not pulling their weight*." – FGD#2.

Dudu:

> "*We do not have proper supervision, everybody does what she or he thinks is right*."

Beatrice:

> "*I would really appreciate it if we can have enough supervision, there is nothing harder than being thrown in the deep end and people expect that you do not drown*."

To improve accountability systems in the government departments in response to IPV, the study participants suggested collaborative programmes that engage departmental organisations, traditional leaders, NGOs, CBOs and residents in shared problem solving around culturally appropriate responses to human rights abuses.

6.4 CONCLUSION

This chapter highlighted the secondary intervention programmes for IPV in the Msinga area. Although some IPV intervention programmes show promise, further research in this area is essential. Following the ecological model, Lori (1998) argued that the cultural, social and gender norms of a community often make it problematic for victims to obtain support or achieve recompense. Consequently, to successfully respond to matters of IPV and provide suitable support to victims, the socio-cultural environment in which offences are committed must be reflected. The subordination of women to men in most communities is a consequence of the generational gender stereotypes embedded in these societies. Typically, it is primarily women who have borne the impact of offensive cultural practices that propagate IPV. The victim's degree of recovery affects and is affected by all her relationships and experiences including the attitudes and beliefs of the community. Adverse attitudes towards the woman who has been abused impose further abuse on her. Open discussion on IPV diminishes the disgrace associated with it and, in so doing, motivates victims to seek support.

Psychosocial support is fundamental in the care given to victims of IPV. Despite this, such support is not prioritised by other social service providers. Several imperatives relating to psychosocial care for IPV victims are not included in organisational visions and missions. As a result, many gaps remain in the implementation and standardisation of psychosocial care for victims of IPV.

The crisis centre model presented by one of the interviewed NGOs is theoretically very good and has vast potential in providing comprehensive services to IPV victims and significantly decreasing their secondary trauma. Notwithstanding the enormous efforts by the NGOs to provide quality services to victims, their work remains outside the scope of the DSD and the SAPS. As a result, they are not exclusively funded by the government to offer such services. In the face of the mounting prevalence of IPV, it is time for the government to assent to their

obligation to ensure the financial sustainability of NGOs, and in particular, those providing psychosocial services. For areas like Msinga, the NGOs should further lobby government to allow crisis centres to fully operate like the Thuthuzela Care Centres (TCC) and also adjust the legislative framework to allow for the establishment of crisis centres as a formal part of the criminal justice system.

Findings of the study suggest that psychosocial support indicators including societal connectedness, stronger network ties and supportive communities are key factors in nurturing resilience among abused women. Negative family reactions negatively affected women survivors' psychosocial well-being, and accessing formal services was not always positively associated with resilience. As shown in this chapter, the psychosocial services are inadequate and often not easily accessed and the importance of family or community-based support cannot be over-emphasised. In addition to interventions to increase women's utilisation of obtainable services, there is an urgent need to promote stronger social support and social networks in families and communities. The level used here according to Bronfenbrenner's socio-ecological model (1979, 1986, 1994) is the microsystem level of intervention which is the system that is closest to the person and which encompasses the environment in which the individual lives. IPV support groups can be the platforms through which women network with other women who are abused and provide opportunities to acquire instrumental support that could assist them to better cope and foster self-efficacy and self-esteem. Further capacity-building for NGOs to deliver effective psychosocial support within the reach of women is also essential.

CHAPTER 7

TERTIARY PREVENTION INTIMATE PARTNER VIOLENCE STRATEGIES EMPLOYED IN MSINGA AND THE EFFECTIVENESS OF THE STRATERGIES

7.1 INTRODUCTION

In the previous chapter, I highlighted the secondary intervention programmes employed by the NGOs in Msinga in response to IPV. The emphasis was on psychosocial support to aid IPV women survivors with the restoration of their strength. This chapter deliberates on the IPV tertiary intervention programmes. I will first discuss how NGOs assist their clients with the application of protective orders. The education of service providers in the formal setting on handling IPV cases and on the myths and misconceptions around IPV was provided by the NGOs in Msinga. This was essential since IPV happens within a community that sustains certain cultural practices and beliefs. Moreover, survivors of IPV as shown in the previous chapters are likely to interact with several service providers (both formal and informal) in seeking services geared towards addressing their needs and concerns. The cultural environment within which survivors of IPV live as well as the response that they receive from both their immediate and non-immediate environment has an impact on their restoration, healing and adjustment process. The attitude, beliefs and behaviour of the people with whom a victim of IPV interacts with, as well as the processes they are exposed to, have a direct outcome on the distress they experience. The consequences of IPV go beyond those experienced by the victim herself to include the entire community such as instilling fear as well as destroying the social fabric. As a result, education, sensitisation and training on issues concerning IPV must not only include the individual but the community as well.

As alluded to above, this chapter will examine various sectors' engagement in carrying out education and sensitisation regarding IPV. It will also examine the sensitisation and education initiatives of service providers who were involved in providing services to the survivors of IPV. The relationships between the service providers involved will also be discussed. This will be done with the understanding that addressing IPV cannot only be addressed through the delivery of services in a particular sector.

Women skills development was also deliberated with the NGOs, as financial challenges faced by women in Msinga were one of the main reasons for them remaining in abusive relationships.

One of the tertiary strategies used in addressing the needs of women victims of IPV in Msinga was women survivors of IPV taking a stand to help those women who were still victims of the violence. Other women survivors were helped with developing their safety plans to safely guide themselves from the IPV they were experiencing

Promotion of family reconnection and reunification post-IPV is also discussed as are transitional phase and aftercare support. Finally, the barriers hindering the effectiveness of IPV tertiary prevention strategies will be discussed as well as recommendations for mitigating them.

7.2 EFFECTIVENESS OF INTIMATE PARTNER VIOLENCE TERTIARY PREVENTION STRATEGIES

Tertiary intervention programmes refer to the long-term response after violence has occurred. They deal with the lasting consequences of violence and offender treatment interventions. It is evident that when there are violent conflicts, public social systems and professionals must be effectively and efficiently mobilised in response. Tertiary prevention includes the responses to violence and the consequences of violence. It, therefore, comprises the response and the treatment and rehabilitation. However, it goes on to embrace reconstruction, resolution and reconciliation (Middleton & Sidel 2007). NGOs are involved in offering humanitarian assistance to and protecting the human rights of the civilian inhabitants that are directly or indirectly affected by IPV.

Wolfe and Jaffe (1999:136) stated that IPV tertiary prevention strategies “emphasize the identification of IPV and its perpetrators and victims, control of the behaviour and its harm, punishment and or treatment for perpetrators and support for the victims.”

Du:

"…*We had a programme here at LifeLine and Rape Crisis that was mainly focusing on the perpetrators of violence. This programme involved inmates and those that had been released through parole to ensure that they completely transform. They had groups sessions conducted by a male coordinator employed by LifeLine but then the programme had to end because the contract with the funders came to an end*."

Some clients would attempt suicide due to the violence and after the attempt, long-term prevention needs to be considered. Etzersdorfer and Sonneck (1998) argued that in Vienna, the Austrian Association for Suicide Prevention provided media guidelines and launched a media campaign to stop the sensationalist reporting of subway suicide, which was believed to have caused cases of copycat suicides. According to Ludwig and Cook (2000), in 1994 in the USA the Brady Handgun Violence Prevention Act established a mandatory five-day waiting period for buying arms. This waiting period was said to have the potential to prevent impulsive suicide attempts with a deadly weapon. De Leo et al (1995) referred to a prevention method in Italy that focused on elderly individuals with a high risk of suicide. In their study, each participating individual was offered a portable alarm device and the results indicated that there were significantly fewer suicide deaths within the participating group (De Leo et al 1995). To deal with IPV, tertiary prevention interventions are essential. In instances where the law is involved, there are criminal justice interventions such as restraining orders and specialist domestic violence courts (Bellis 2012). For IPV victims in Msinga, some educational programmes and services are offered by the NGOs. The NGOs offer programmes to IPV survivors to help them rebuild their lives; there is also a programme for professionals to enable them to understand IPV and how they can assist victims.

Tertiary prevention involves efforts to diminish the progression of a problem once it is already clearly evident and causing harm. The IPV tertiary prevention strategies discussed in the FGD#2 included teaching safe and healthy relationship skills; involving influential adults and peers; disrupting the developmental pathways toward IPV; forming protective environments; strengthening economic supports for families; and supporting survivors to increase safety and lessen harm. Below are the IPV tertiary prevention strategies that were discussed in-depth during the individual interviews with the NGO staff and the focus group discussion (FGD#2) with them.

7.2.1 Application of protection order with help of NGOs

In some situations, restraining orders were used by the NGOs in Msinga as a risk management strategy to reduce the likelihood of re-victimisation of IPV clients. Vetten (2005) citing the DVA No. 116 of 1998, stated that the protection order is provided to those directly affected by domestic violence. While this research focused on domestic violence within intimate relationships (past, present or perceived), it also occurs in other domestic relationships such as family members or people who are sharing a living space. The DVA allows victims to apply for a protection order against perpetrators of abuse. It is also mentioned in the DVA that other family members are also eligible for protection if they are directly affected by the violence.

Beatrice:

> "*We also enlighten our clients about the options they have in order to reduce incidences of IPV. Among others, we talk about the protection orders*…"

Nqobile:

> "*We teach our clients how to apply for the protection order then the client decides if she would apply for it or not as we cannot force them to do what they do not want to do*."

It emerged during the interviews that protection orders, both temporary and permanent, seem to serve an explicit function for women in addition to protecting them from their abusers. Based on in-depth interviews with women who had applied for protective orders, Fischer and Rose (1995) found that women felt protective orders told their abusers that society did not commend their behaviour. In the FGD#2, it was explained that having a protection order also served as documentation of the abuse, making it a matter of public record should anything happen to the woman. It also served as evidence to the police that the woman was serious about ending her abuse. For women survivors of IPV, taking the step of obtaining a protection order improved their sense of self-efficacy and control.

7.2.2 Sensitisation and education of service providers in the formal setting

Notwithstanding the alarming number of women affected by IPV, the literature has called attention to the lack of IPV training of service providers. According to Bozorg-Omid (2006), only 50% of the counsellors surveyed had received graduate training on the subject of IPV and of those, 78% reported that the training was insufficient. Unfortunately, this lack of training repeatedly leads to the perpetuation of existing myths and misconceptions regarding IPV. The field of IPV is a challenging one, not only because of the abundance of misleading information and additional layers of challenges (for example, developing safety plans and risk assessment) but because many other service providers are often involved. These include police officers, attorneys, social workers, community workers and counsellors, among others.

The NGOs' education on and sensitisation to IPV have thus included myths and misconceptions that are held by the general public as well as other service providers. The assumption is made that these myths and misconceptions may also apply to counsellors and counsellors-in-training. Based on the interviews held with NGO staff, it is important for service providers to not only be conscious of their own values and perceptions regarding IPV but to also recognise the implications that the IPV survivors' interactions with other service providers may have on the survivors' overall experience with IPV.

Apart from reaching out to and sensitising the community, some NGOs were also using the sensitisation method to address potentially harmful beliefs and attitudes of IPV among key service providers such as the police, social services and healthcare providers. The service providers, be it police, healthcare, or social services share comparable deprecating attitudes like those of the community at large and these can, therefore, be severe obstacles towards improving the quality of care for victims of abuse (Ellsberg 2006; Heise 1998). Moreover, in most instances, the service providers live within cultures where these false and misleading notions of IPV exist and, if they are not challenged, they can accept and validate male violence against women. As most service providers are from the same community, they themselves may also have a history of violence as victims or abusers. Ellesberg (2006) stated that those experiences and attitudes undoubtedly impact on the way they will react to persons living with violence. It is important to note that attitudes portrayed by service providers concerning IPV play a fundamental role in their providing support to women survivors including their pursuit

of justice. The situations need the unbiased involvement of many service providers to help the survivor, take her through the system and bring the case to justice.

Ntombifuthi:

> "*How we as service providers engage with survivors is critical. The empathy exhibited by us could impact on how much victims disclose and whether survivors are traumatised again through our engagements with them so it is for this reason LifeLine and Rape Crisis continuously train some service providers here in Msinga on how to handle an intimate partner violence case from opening to finalisation*."

According to Davis and Carlson (1981), attitudes and beliefs of 500 social workers, health service providers, police officers, and family court judges toward victims of domestic violence and their abusers provide evidence that most service providers blame the victim. Respondents, particularly social workers and healthcare providers tended to focus mainly on those causes least amenable to change, namely, the characters of both husband and wife.

Thembelihle from the Khayelisha Care Project stated that organisations such as LifeLine and Rape Crisis have been vigorously involved in sensitising police officers and other service providers on various issues such as human rights, through workshops and seminars, to enlighten them and change their attitudes towards victims of abuse. The undesirable attitude of the Msinga Police station was highlighted in the previous chapter and reflected in the comment by one of the women survivors below:

> "*… it is really hard here in Msinga, you would go to the police station to report a case of abuse and they would just unconditionally blame you for triggering the abuse*." – Zothile.

It is true that in many communities, police officers play a "gate-keeping" role when determining whether or not a crime did occur and if so, how to categorise and probe it. Seelinger (2011) has shown that in societies where women have low social status, it is imperative that police are educated about violence and victims' rights if women's access to justice for crimes is to become a reality.

On other occasions, the NGO participants held joint education and comprehensive sensitisation meetings with service providers from the healthcare, psychosocial and legal sectors, among others, on preventing IPV. As pointed out earlier, addressing matters of IPV entails a multi-sectoral approach whereby survivors obtain support and perpetrators are brought to justice as a result of coordinated activities across numerous sectors (Wardlaw et al 2006). Collaboration is also essential as it leads to more effective and efficient use of resources by sharing expenses, minimising the replication of efforts, fostering coordination among groups and increasing the overall impact (Davis et al 2006).

7.2.3 South African Police Services being capacitated in handling issues of intimate partner violence

The police, being the frontline social institution to deal with incidents of IPV, have a critical role to play in assisting victims of IPV to follow through on their decision to seek recourse for the abuse (Corcoran et al 2001; Glanz & Spiegel 1996). The police not only signify state policy but also act as a significant link to both the prosecution process and to the provision of services to victims in a community. It was for these reasons that LifeLine and Rape Crisis started to work with the SAPS in Msinga in dealing with all forms of abuse happening in the area. LifeLine and Rape Crisis confirmed that they placed their well-trained lay counsellors in the Msinga police station to offer support in dealing with incidents of IPV.

Du:

> "…*we also workshop police officers in making certain that cases of forms of violence are dealt with in accordance guided by the acts. However, for many victims of domestic violence, the police become the last resort, except when the victim decides to take that first bold step towards seeking redress*."

In the FGD#2, it was revealed that gender issues were also evident in that female police officers were not comfortable with performing duties regarding IPV complaints while their male counterparts appeared to be more willing to attend to such cases.

Du pointed out that the SAPS were at times unhelpful to the survivors of IPV when emotional and psychological abuse were involved as they would say they want evidence.

Du:

> "*[Emotional and psychological abuse]is the most problematic to identify as you rarely see any noticeable signs like for physical abuse*."

> "*In most cases, police officers dodge dealing with emotional abuse as it is problematic to identify elements of a crime ... or imminent danger as there are no visible outward signs, they would start attending your case if you present with bruises and at times, they will tell you to go back and resolve the matter as a family ...*" – FGD#1.

The findings show that participants in the study believed that police officers found emotional abuse extremely challenging to handle because of the lack of visible proof and the psychological manipulation of the victim by the abuser. Browne and Herbert (1997) and Sanderson (2008) also support the contention that emotional abuse is more difficult to detect than other forms of abuse. As a result, emotional abuse is not always reported and if reported, not recorded properly.

Given the significant role that police officers play in the safety of survivors and/or victims, it is critical that they (and other IPV service providers) have sustained training in the area of IPV. Such training, however, needs to have an increased focus on listening to the opinions of the survivors and/or victims, as well as on empirical facts as revealed by research on IPV. Horwitz et al (2011) suggested that aside from supplementary training in domestic violence, police officers would also benefit from opportunities to debrief and receive feedback. Experiential activities such as role-playing could be used to offer real-life examples in the effort to challenge police officers' assumptions and preconceived ideas concerning victims of IPV.

It is also important to acknowledge that like other IPV strategies, tertiary prevention strategies are difficult to implement successfully. This is because they deal with persons who are, to a large extent, either intimately connected or close associates with the perpetrators whom they usually do not want to go to prison. Sleath and Smith (2017) revealed that a huge number of IPV cases are withdrawn at the police investigation level. Even if the law enforcers refuse to permit withdrawals and take the perpetrators to court, the victims do not turn up to tender evidence and the legislation has no provisions as to further courses of action in such an instance. Reasons for not pursuing legal recourse vary from love to culture. As a result, some participants felt that the law should focus more on the victims and they should be engaged in discussions

on how they could resolve their challenges without the prescription of punishment. Nonetheless, some doubt was cast on this position because when asked whether there should be a law to compel wives as "victims" to testify against their husbands in wife battery cases, it emerged that the majority of the NGO participants in the FGD#2 wanted such a law to be sanctioned.

7.2.4 Bolstering public education campaigns on myths and misconceptions about intimate partner violence

During the interviews with the NGO staff, it was found that the public education campaigns were also undertaken to sensitise communities to not offer safe havens for the perpetrators of GBV including IPV. Much effort was geared towards co-opting traditional leaders (chiefs and *izinduna*), traditional healers and school governing bodies in educating communities about their responsibilities in eradicating GBV and IPV and decreasing the stigma that surrounds the survivors.

> "*In this community, there is a necessity to speak out concerning false information and myths that uphold intimate partner violence*…" – FGD#2.

Nokwanda:

> "*It is through our many interactions with both our clients and colleagues that we have become conscious of how specific myths and misconceptions about intimate partner violence may lead to severe implications for the victims*."

It is apparent from the above excerpts that addressing the public about the false information and myths could assist in IPV survivors' recovery and adjustment. Even though tertiary prevention strategies should be planned with sensitivity and respect for culture and tradition, enhancing and protecting women's rights will consistently involve challenging the normative social values that promote IPV. Supporting the improvement of healthy, respectful, and non-violent intimate partner relationships has the possibility of reducing the incidences of IPV. It can also inhibit the damaging and long-lasting effects of IPV on individuals, families and communities.

7.2.5 Provincial Victim Empowerment Management Forum (VEP) being part of the solution to intimate partner violence

One of the NGOs I interacted with confirmed that they were participating in the provincial Victim Empowerment Management forum (VEP) as part of the solution to IPV. This is a platform where they learn from other stakeholders about assisting in handling cases of abuse. They also seek advice on the platform. The other three NGOs did not have a full understanding of what the VEP involved. However, the participating NGO stated that it was facing human and material resource constraints, which impacted negatively on its ability to render comprehensive services. The conclusion drawn from this is that the VEP has a low profile amongst rural communities and even the service providers, resulting in many potential clients not knowing that the VEP services were available to them. The individual departments and NGOs that are supposed to be part of the victim empowerment sector tend to work in silos and this could result in a poorly integrated and coordinated service stream in respect of victims of crime.

> "*… this [the VEP] was meant to be a good initiative in promoting a good referral system. However, existing referral systems are ad-hoc and uneven*." – FGD#2.

The NGOs agreed that there was a need for a referral protocol that outlined the roles and responsibilities of all the stakeholders involved with victims and to guide the identification and referral of victims to appropriate VEP services.

7.2.6 Skills development among women survivors of intimate partner violence in Msinga

Feminists have fought and continue to fight for a woman's right to have control over their practical requirement of autonomy. Skills development is considered a critical strategy to empower rural women to escape from abuse. LifeLine and Rape Crisis encourages their women survivors of GBV to become counselling volunteers.

Nokulunga:

> "*For you to become a counselling volunteer at LifeLine, you first need to undertake a four-month personal growth and interpersonal skills training. This course is the*

fundamental requirement for preparing women to become good counsellors and community workers. I also started there…"

The course mentioned above is also said to enhance the women's growth and self-awareness as well as their capacity to hear and relate more meaningfully to others.

Nokulunga:

"*The personal growth course is a very moving and challenging process at the same time. We are taught in small groups, each with two experienced LifeLine facilitators. Core subjects emphasised are respect, non-judgment and personal responsibility – based on the person-centred approach*."

Among the other courses offered by LifeLine and Rape Crisis is the "Gender-based Violence" course which takes five weeks. This course is mainly directed at the women survivors and victims of abuse. During the training course, women learn about the different forms of abuse, its warning signs and the potential damage abuse may cause. Legalities and reporting procedures to put a stop to the abuse are also covered.

Ntombifuthi:

"We take great care to establish a safe and appropriate space and while the greatest growth comes from full involvement in the group, no-one is ever coerced to participate. The trainees are motivated to experiment with their own reactions and responses to others, and to learn better and more effective ways of communicating."

The course comprises two modules and on completion, those women who wish to may put themselves forward for selection as counsellors. These findings suggest that a skills development programme for women, in particular, may improve their self-esteem, lower depression and improve their general well-being.

7.2.7 Survivors helping victims: Women IPV survivors helping others

Seven of the women survivors who participated in the study stated that they are in a group of women who survived violence on their own. The group was receiving support from one of the participating NGOs and was very grateful for the support received.

> "*We are ten of us, the brave women in this area. All of us endured years of physical, emotional and sexual violation by our male partners. One survived being shot. And we did not always get the help we needed from the system*…" – Thobekile.

By telling their stories, these survivors were letting other victims of IPV know that it is possible to rise above the challenges they are faced with including the trauma of IPV and the injustice of the system. They were using their lived experiences to aid others, and showing that there is always a way out. One of the interviewed NGOs used this group as their source of reference should they need advice. The relationship they had was a give and take relationship, as this group would also learn from the NGO.

Thobekile:

> "*Let us not just point victims of violence in the right direction, let us walk with them…"*

7.2.8 Use of a safety plan should the incidents of abuse reoccur

From what was shared during the interviews suggests that if abuse is present, it may be essential to develop a safety plan with the victim by providing knowledge and correct information about community resources, bearing in mind that the service provider may have been the first person that the victim reached out to. In a similar vein, it is crucial to make a proper referral by deliberating with the perpetrator the significance of attending specialised treatment programmes that could assist him/her to learn new non-violent problem resolution skills focused on power and control dynamics.

It was also discovered during the FGD#2 that a safety plan is a personalised, practical plan that contains ways for a woman survivor to remain safe while planning to leave an intimate relationship as well as after having left the relationship. The NGOs use it as a mechanism to

inform survivors of IPV on how to cope with emotions, tell friends and family about the abuse and take legal action. It was advised that safety plans should begin from the assumption that the perpetrator is dangerous and, as such, assist the victim or survivor to identify the circumstances under which the perpetrator typically becomes violent and how the perpetrator may react to help-seeking strategies.

Thembelihle:

> "*We are regularly confronted with women and children who reside in violent or potentially violent living environments and they are not willing to leave. We then found ourselves deliberating some safety plans with them that they can use to promote their safety and the safety of children living in that unsafe family situation*."

Callister (2002) argued that it is usually presumed that children who have been involved with or assessed by a child protection agency are being monitored and are likely to be in safe environments. The sad reality is that most children often continue to live in, or are returned to, living environments that have the potential for serious violence (Castelino 2009). For instance, Black et al (2008) found that only 10% of children who were exposed to and experienced some form of maltreatment were placed in out-of-home care settings. Black et al (2008) argued that a majority of cases involving child exposure to violence are closed with no removal from the home and with a restricted focus by social services or other helpers on safety planning efforts. The interviewed NGOs also confirmed that their local DSD could not help them with cases in which children needed to be removed from an unsafe environment. The DSD complained of the limited resources they were working under.

Nthombifuthi:

> "*I remember when we started sensitising women about domestic violence, we used to tell them that we could link them with resources like place of safety, children's home, foster care placement, you name it. However, the existing systems used to work against us because neither of those could happen and we would then sound like a broken record when trying to explain to our clients what went wrong…*"

As a result, the NGOs opted for safety plans.

Concern about the non-removal of children experiencing abuse from the home was expressed in the focus group discussion:

> "*… this is really disturbing as we have a mandatory duty to report child abuse or neglect to an independent social service agency and yet we found that the majority of cases that involve child abuse and/or child exposure to IPV do not result in the removal of the child from the home*." – FGD#2.

It was learnt that if children are exposed to IPV and left in a potentially unsafe environment, NGOs have an obligation to enhance their safety. Thus, NGOs play an essential part in aiding abused women with no means to escape, and underage children with no power to leave their home environments. It was also learnt that NGOs could not assume that just because the mother's (abused woman) safety needs had been met, that the child's safety needs had also been met (Waugh & Bonner 2002). Even though the woman may actively be working to improve the environment, the social worker or counsellor needs to also empower the child to work toward securing his or her safety. Kress et al (2008) claimed that an alternative and empowering approach to helping children cope with violence in the home is client safety planning. For the Msinga NGOs safety planning entails having both abused women and children develop a detailed plan that could be used to enhance their safety. Safety planning permits abused women to take a dynamic and powerful role in their own (and their children's) safety and is not focused solely on the use of physical or emotional coping skills.

7.2.9 Promotion of family reconnection and reunification post intimate partner violence

Most of the staff members from the participating NGOs concurred that family reunification is not the ultimate goal for every case. It was agreed that family reconnection and reunification should only be considered if safety can be maintained for everyone in the family, particularly the safety of the woman who was victimised. Ideally, as part of the recovery process, the family will develop a structured way to acknowledge and deliberate how they will manage these issues including the damage the abuse has caused and the impact on everyone who has been affected.

Tabachnick and Pollard (2016) argued that the process of "reunification" involves developing and implementing terms for determining how or whether to restore relationships. Family

reunification was also found to be an intervention in families to prevent the recurrence of the situations and behaviours that caused harm. All the interviewed NGOs stated that they did provide family reunification to the survivors and perpetrators of IPV as well as the children involved. However, the NGOs did not have a structured way of providing such an essential service. They had all shown that they sometimes used their instincts when dealing with cases of IPV.

Du:

> "*We use different techniques and mix … that is where we talk of life experience, remember we are also part of the community and we have also gone through what they are going through*."

Thembelihle*:*

> "*Remember some of us chose this career only because we wanted to learn some ways of helping ourselves and others who suffered like us, people say experience is a good teacher*…"

Even though this discussion of service approaches to addressing IPV identifies specific interventions, these are far from distinct strategies. There is extensive overlap in the specific services provided by each intervention programme which raises the critical cross-cutting question of which elements in this set of intervention programmes are most effective in preventing and treating IPV. Nonetheless, the specific interventions discussed in this chapter have been identified in the field and the literature, in turn, has developed from these services as they are identified.

It was essential for the NGOs to provide such reunification services on behalf of families as these families would not be able to face some of the questions that arise in any formal reunification process such as establishing effective boundaries, safety, and the likelihood of future harm. If this was not done, families would not have the support, experience and additional accountability provided by the NGOs involved in reconnection and reunification, thus increasing the risks for all involved.

"*Even though we can provide such services but we cannot address all the complexities of some situations in other families. Services offered here may be useful to families who are interested in creating a safety plan and developing the skills to adequately implement that plan*." – FGD#2.

7.2.10 Post intimate partner violence and couple's counselling

NGOs have conducted couple's therapy when working with couples experiencing IPV and have reported differing but promising results. One of the most significant elements when conducting couple's counselling with a survivor and a perpetrator is understanding the potentially harmful effects that this approach may have on the survivor if not done correctly. First and foremost, it is imperative to safeguard the client's safety.

"*Sometimes it becomes beneficial to make a good practice of meeting with individuals separately before any couples counselling sessions to gauge whether or not any physical, emotional, and/or sexual abuse is happening in the intimate relationship*." – FGD#2.

Nokulunga:

"*Moreover, it may be useful to play it very safe by permitting the couple know that you will decide if it is appropriate to see them together in follow-up counselling sessions or not...and inform the intimate couple that even if they are seen independently it will be considered as couple counselling*."

Beatrice:

"*We are also human beings, having experiences with other people and then processing it in couple counselling can be very powerful and helpful to recovery and restorative… We can be great buddies and rejoice with clients when they try something new*."

The above is only done if the intimate couple chose to work on relationship issues.

7.2.11 Transitional phase and aftercare support

It was discovered during the FGD#2 that the Khayelisha Care Project had a programme called "Aftercare" which assisted the survivors of IPV with transitional assistance. The Khayelisha Care Project aimed to restore and protect the economic security of victims of violence. The programme was a 12-week one implemented over one year. The programme provided case management for housing and job assistance, individual face-to-face counselling, and facilitated support groups for violated women over the age of 18 years who were exiting from the Khayelisha Care Project shelter. The ultimate goal was to empower 50 abused women over the course of one year by assisting them in gaining and regaining economic self-sufficiency and promoting autonomous skills. The 12-week programme aimed at equipping women with the necessary knowledge and skills that would enable them to reject abusive relationships and evade re-victimisation.

Thembelihle:

> "*The main aim of this programme was to offer an effective follow-up service that focused mainly on enabling female victims of intimate partner violence leave the cycle of violence by regaining their independence in order to evade the reoccurrence of violence in their lives …[and] To offer case management for housing and job assistance in order to improve economic self-sufficiency. We also provided individual counselling in order to condense the psychological effects associated with the victimisation of intimate partner violence*."

Dudu:

> "*We also provided emotional support by facilitating personal empowerment support groups…This programme was an additional of what we are providing at Khayelisha Care project and to name the few, we offer services to victims of domestic abuse that includes safe housing, counselling, legal assistance, employment support, financial literacy training, and supportive children's programmes*."

It also emerged in the in-depth interviews with the women survivors of IPV that the aftercare programme helped them to achieve sustainable freedom throughout their lives.

> "*Community workers from Sinozwelo Resource Centre would visit me at home to see if I was still okay*…" – Snegugu.

7.3 BARRIERS HINDERING THE EFFECTIVENESS OF INTIMATE PARTNER VIOLENCE TERTIARY PREVENTION STRATEGIES IN MSINGA

While it is important to identify sound and progressive tertiary strategies, it is equally important to identify barriers in order to alleviate them. Moura (2012) mentioned the necessity to comprehend the obstacles to scaling-up as a contribution to organisational learning and growth. In-depth interviews and the focus group discussion with the NGO staff highlighted three overarching constraints, namely, inadequate and at times unacceptable responses to IPV by the service providers, a weak institutional capacity that can cause IPV projects to fail to achieve their goals, and the breaching of terms and conditions of interim protection orders.

7.3.1 Service providers' inadequate and unacceptable responses when working cases of intimate partner violence

The staff of the NGOs pointed out that some service providers are still yet to comprehend that by using shaming language, ineffective strategies and creating unrealistic expectations, they are placing more barriers for the victims. In doing so they make it more difficult for the victims to "to step out" of the abusive or violent relationship.

Findings of the study revealed that women IPV survivors who had multiple encounters with police stated that police officers joked about their situation and made undesirable statements such as "Well, what do you want me to do about it? He'll just be back tomorrow." In addition to making the challenging decision of calling for assistance, it is essential to note that involving the police may increase the risk of further violence against the victim by the perpetrator.

7.3.2 Weak institutional capacity contributing to the ineffective implementation of intimate partner violence programmes

The participating NGO staff pointed to the absence of operational protocols and procedures for assisting and supporting women and girl survivors of violence. Protocols and procedures need to be in place for interviewing survivors, investigating IPV crimes, documenting IPV, and for referrals to health, psychosocial and legal services (Bastick et al 2007). However, as pointed out by one of the NGO participants, this was not the case.

Nqobile:

> "*In most cases, we follow our instincts in handling cases of intimate partner violence*…"

During the focus group discussion with the NGO staff, attention was drawn to the fact that the NGOs were working under no gender-responsive codes of conduct and policies on discrimination. It was for these reasons that IPV projects were often implemented ineffectively. There is thus a need for codes of conduct and policies to be implemented with proper training, and for internal and external accountability and oversight mechanisms to be established (Bastick et al 2007).

Thembelihle:

> "*The lack of community policing forums, civil society organisations, including women's groups and survivors of violence, to identify required reforms and to ensure that protocols and procedures that are responsive to community needs lead to unsuccessful delivery of IPV services in this community, like in other communities*…"

The above-mentioned improvements can assist the IPV service providers to gain legitimacy and credibility in the eyes of the general public. Institutional capacity and integrity are key qualities essential for IPV service providers to fulfil the technical requirements of their work in helping the victims of IPV. Crucial too, is the need for them to act in accordance with human rights, professional, ethical and rule-of-law standards.

7.3.3 Breaching terms and conditions of interim protection orders

It was acknowledged in the FGD#2 that dealing with domestic violence is complicated by the emotional, familial and economic ties between people in intimate partner relationships. It is because of these ties that domestic violence is not as readily resolved by single criminal justice interventions as crimes committed between strangers.

Nqobile:

> "*We have been encountering some people that would come to us to assist them with information on how to apply for the protection order. We would educate them and even escort them to court to apply for the protection. When we get there, you would hear them starting to ask lots of questions showing that they are now having second thoughts*…"

Beatrice*:*

> "*Some would go and receive the interim protection order but when they are due for the protection order to be made final, they would not appear to court*…"

As noted by Felson et al (2002), some factors that keep IPV victims from requesting assistance include the desire to keep the abuse private and the fear of their partners' retaliation.

> "*We have noted that a significant number of victims have stopped following the application of protection orders, regardless of whether the client is free or not free from the violence*." – FGD#2.

Very few women who had received the protection order would report that the perpetrator had "promised" to stop the abuse while there were other women would report that the perpetrator had begged and pleaded that they not go back and finalise the order. It was also found that the family members also attempted to either mediate or dissuade the woman from returning to court. More worryingly was the NGO staff in the focus group discussion indicating that most of the women were threatened by the male partners if they returned to court. Some IPV

survivors during the individual interviews stated that while they did apply for protection orders, doing so, however, had not worked for them as the abuse had become worse. As also revealed by Artz (2008), some Msinga participants reported having stones thrown at their windows or being locked and restrained in their homes by the perpetrator or other family members.

Artz and Moult (2001) stated that on any given day there may be between 20 and 50 submissions for protection orders and hearings for domestic violence cases at each court, and up to half of the hearings may involve "non-returns". Sadly, some victims of IPV are frequently threatened with death or more violence if they initiate criminal justice proceedings.

> "*My partner came to my home and demanded that I must go with him to talk things through. As I refuse to do so he began banging on the door and then proceeded in punching me with his fist. I had to cry for help and fortunately, my sister was at home on that day … as we got near to the police station, we noticed that he was already waiting opposite the police station with his friends who were looking so dodgy carrying a gun in his hand. He then walked next to us and started swearing at me and saying 'You are sleeping with the policeman; you are a whore.' He then threatened to get somebody to kill me if I proceed with suing him. I was so terrified…*" – Nomalanga.

It is apparent that the issue of attrition in IPV cases is a complex one, with several often interrelated factors impacting on an applicant's decision-making concerning finalising a protection order.

7.4 CONCLUSION

This chapter has shown the importance of education and sensitisation of community members and service providers as interventions in responding to the needs of the women survivors of IPV in Msinga. The findings showed that intervening and offering information to survivors at the individual level is essential in informing IPV survivors of the accessible services (such as applications for protection orders) for obtaining various forms of support. Also emerging from the findings was the need to provide formal service providers with the knowledge and skills to handle issues of IPV using tertiary prevention strategies. This was done to modify existing negative attitudes among service providers towards the survivors of IPV. Doing so was because

negative attitudes and beliefs within formal systems have been found to have detrimental effects on survivors' physical and psychological well-being and also lead to secondary victimisation. The sensitisation on IPV was also aimed at reducing its occurrence and in doing so, protect the public by diminishing the damage and suffering that are its direct consequences.

A further finding was that various service providers (both NGOs and government departments) were involved in educating and sensitising the community of Msinga. Sociocultural factors such as gender norms, existing attitudes and beliefs about IPV in the community determined their response towards the women IPV survivors. Henceforth, bolstering public education and campaigns dealing with the myths and misconceptions concerning IPV; aiming at modifying the negative attitudes towards women who have been abused by their intimate partners; and challenging the regressive cultural values working against these women, are three crucial responses to consider.

The NGOs and public systems must ensure the availability of, and accessibility to IPV services, including justice for individuals exposed and affected by violent attacks. The NGOs and public systems should address the concerns of the communities that are directly or indirectly affected by violence or terror threats. The SAPS must ensure, not only the safety of the women survivors of IPV but also that of the service providers. In terms of the latter, an NGO staff member related her experience:

Dudu:

> *"I helped the client with opening a case of intimate partner violence in our police station and the accused was always following me trying to harm me…"*

It was also transpired that the NGOs and government department should collectively endorse IPV tertiary prevention strategies to enhance resilience in the event of violent actions. In circumstances where IPV does occur, it is important to effectively collect data surrounding the violent incidences to inform future cases.

Women skills development also emerged as an important consideration in terms of winning the battle against IPV given that many women survivors were found to be highly dependent financially on their male partners which provided the partners with the leverage to have control

over women. Without skills, women struggle to find employment and thus remain dependent. However, the women survivors had taken a stand in terms of helping themselves and others in the fight against IPV. Finally, in some situations, NGOs were forced to promote the safety plans for their clients living in violent families and also provide family reconnection and reunification because of the limited resources they were working under.

The following and final chapter provides a summary of the findings, the key contributions of the study and suggestions for further research.

CHAPTER 8

SUMMARY OF FINDINGS, RECOMMENDATIONS AND IMPLICATIONS OF THE STUDY

8.1 INTRODUCTION

This chapter will start by briefly presenting a summary of the key findings from the perspectives of both the women survivors of IPV and the NGO members of staff. The contribution of the study will be also discussed and this will be followed by the commonly shared recommendations as deliberated by the research participants. The recommendations of the women survivors of IPV will be presented first, followed by those of the NGO staff. The implications of the study for policy, practice and further research will then be presented. The chapter (and the study) ends with a conclusion.

This was an empirical study that used primary data. It adopted a qualitative research approach located in the interpretivist paradigm to examine the experiences of women survivors of IPV and the effectiveness of programmes being employed by organisations dealing with IPV in Msinga, KZN, South Africa. The reason for choosing Msinga as the study location was that Msinga is one of the rural areas in KZN in which women suffer gross IPV perpetrated by their male partners. It is also one of the rural areas that has a long history of communal violence going back to the late nineteenth century which has resulted in unique institutions and behaviours that have influenced gender relations in Msinga.

The literature review identified similar studies on primary, secondary and tertiary strategies addressing short- and long-term needs of women who have suffered IPV in both global and local contexts. It was revealed that most areas where IPV programmes have been employed are characterised by strong patrilineal systems. However, in the Msinga context, the IPV experienced also emanates from a combination of socio-economic issues. Even though the study was situated in the Msinga community, the women survivor's narrations, experiences, perceptions and expectations arguably reflect environments that have experienced similar violence not only in Africa but further afield as well.

In establishing the effectiveness of the programmes, the study relied heavily on the experiences of the women who had suffered IPV and other key informants, namely, NGO staff. The study adopted the post-structural feminist theory of IPV and the socio-ecological model of intervention. Under the post-structural feminist theory, the study found that the IPV that was perpetrated on women in Msinga was mainly rooted in the strong presence of patrilineal systems and cultural beliefs that have characterised Msinga's context. In this regard, most women survivors pointed out that as long as a woman had an intimate partner, she needs to be ready to conform to the authority or will of her male partner. The post-structural feminist theory views the social world in a way that lessens the forces that build and support inequality, oppression and injustice and, in so doing, promotes the pursuit of equality and justice. Therefore, men perpetrate violence against women through the desire to exercise their dominance upon women and assert their masculinity. This study examined how women are perceived or treated by men, not only during times of peace but also during times of violence.

The study made use of purposive sampling to select 32 primary participants, that is, women in Msinga who were survivors of IPV. A semi-structured interview guide was applied as a data collection method. Four NGOs (the Khayelisha Care Project, the uMusa woMsinga Project, LifeLine and Rape Crisis and the Sinozwelo Resource Centre) involved in IPV interventions, were used to assist in accessing the primary participants and eight key informants were selected from the organisations themselves. The key informants from the organisations comprised an executive director, a GBV manager, two social workers (one of whom was a social auxillary worker), two community care workers and two lay counsellors. These key informants provided valuable information on how the IPV programmes that they implemented as organisations responded to the needs of the women survivors of IPV and the barriers they faced. They also provided key recommendations for addressing survivors' needs more effectively. It was revealed in the findings that their programmes use both proactive and reactive approaches.

In addition to the semi-structured interviews, the study utilised focus group discussions. Two such discussions were held – the first with the women survivors of IPV and the second with the NGO members of staff. In understanding that IPV is multifaceted, it was necessary to get the perspectives of those who had experienced it as well as those who assisted in responding to it. Few "actors" were involved in providing services to the women who had been violated by their partners in Msinga, and I was able to establish the collaborative efforts of these actors,

the challenges they faced in their collaborations and how they steered their way in mitigating the barriers.

The study adopted the thematic analysis technique in analysing the data collected. It determined the key issues as well as classified the relationships between the themes.

8.2 KEY FINDINGS OF THE STUDY

8.2.1 Key findings on the experiences of women survivors of IPV in Msinga.

One of the findings of this study was that IPV has devastating physical, psychological and socio-economic impacts not only on the women survivors but also on their families and the community at large. The study further revealed that in the process of seeking services geared towards relieving their suffering, women interacted with various formal and informal support systems. The informal support systems included the nuclear and extended family members, friends and church members. In terms of the socio-ecological system, this level of interaction is referred to as the micro-system level of intervention. The formal support systems included the medical, social, legal and financial institutions which are referred to as the mesosystem level of intervention in the socio-ecological model. While the women survivors of IPV anticipated a positive reaction from the support systems that they approached, in some instances they received negative reactions from both the formal and the informal support structures. At the micro-level system of intervention, for example, women experienced rejection by their in-laws, their own family members and even the community.

Societal and cultural factors operating at the macro-system level of intervention in Msinga were also uncovered. The societal and cultural factors included IPV myths, the subordination of women and an emphasis on male supremacy all of which influenced the shaping of the behaviour and intervention of those whom the women mostly interacted with. The stress on women submission and the acceptance of IPV myths were core contributors to the undesirable reaction that women received from the informal support systems. The formal institutions, likewise, were not exempt from the cultural and societal factors – women also experienced negative reactions from institutions such as the SAPS. The same societal factors shaped the behaviour, attitudes and perceptions of some of the service providers employed by the SAPS. By and large, these services providers were male.

8.2.2 Key findings on the prevention strategies employed by organisations dealing with IPV in Msinga and the effectiveness of the strategies.

The findings also revealed that that the government, NGOs, faith-based organisations and CBOs intervened in various ways in addressing the needs of the women who had suffered IPV in Msinga. Although the NGO staff were disgruntled by the government's degree of intervention into the plight of women survivors of IPV, they nonetheless believed that the government was mandated to take the lead in addressing the women survivors' needs. One of the reasons for the NGO staff voicing their unhappiness was how the government unsuccessfully assigned and dispersed funds to help the victims of IPV. According to the NGO staff, their projects were mainly funded by international funders.

Notwithstanding the presence of international conventions and accords which clearly recognise the role of the state regarding human rights' violations coupled with a vibrant South African Constitution, the findings found that most women survivors of IPV had given up on receiving justice for their cases. The study has shown that initially many women were optimistic that the government was dedicated to ensuring that justice would be realised for them particularly with the setting up of the Commission on Acts of Violence into the Safety and Security (Policing) Government in 2007/2008. However, this optimism appears to have diminished for the majority of women.

Like other countries internationally, South Africa is a signatory of several international and regional conventions such as the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) (which was signed in 1993 and ratified without reservation on 15 December 1995) which force states to cease from indulging in "violence as well as to punish and compensate victims of violence" (Aura 2014). For example, CEDAW allows for states to be faulted for failing to display "due diligence" in preventing or punishing those who perpetrate violence in both the public and private domain. Chapter 9 of the South African Constitution emphasises the promotion, protection, development and attainment of gender equality. However, the study found that the existence of these conventions has not fundamentally translated into the realisation of justice for the victims of IPV who, in the main, equate justice to the apprehension and prosecution of perpetrators. This situation is not unique to Msinga but apparent in many other conflict situations where widespread IPV is prevalent.

Another significant finding established that women's marginalisation, discrimination and subordination were not new manifestations in Msinga; they existed in the indigenous Msinga community. It was found that women were disqualified from leadership positions during the apartheid era and this has continued in the post-apartheid period. This has meant that women did not occupy key positions through which they could influence the traditional or cultural beliefs and address issues that concerned women such as GBV including IPV. Thus, women continue to suffer from IPV in this post-apartheid period. The attainment of freedom has not translated into gender equality notwithstanding the role that women played in the struggle for freedom. This has meant that women have continued to be excluded from the most significant spheres of life such as the social, economic and political arenas. Consequently, women have continued to be observed as unequal entities in interpersonal relations and hence regarded as men's possessions over which men compete (Ellis & Bettie 1983). Differences in gender characters, roles and behaviours often generate inequalities, whereby one gender becomes empowered to the disadvantage of the other (WHO 2012). As a result, in many societies, women are perceived as subordinate to men and have lower social status thereby permitting men greater control and decision-making power over women.

Also established in the study was that IPV against women cannot be delineated outside of the social and cultural context in which it occurs. Therefore, addressing intimate partner violations requires that programmes are designed to take into consideration the socio-cultural factors such as these among others *(ukuthwala, the payment of the bridewealth (lobola) serving to formalise the handover of the women's reproductive rights to her husband's family and the principle of primogeniture*) inherent in society for them to be successful and sustainable. The study findings revealed that in societies where the definition of manhood is powerfully associated with supremacy and toughness IPV is common.

The study found that most women survivors of IPV were uninformed as to where they could find services to assist them, specifically those based at government institutions such as psychosocial support services.

Importantly, it emerged that even though IPV traumatised the lives of the women survivors in several ways they were, nonetheless. able to adopt some coping mechanisms that empowered them to restore their lives. It was pointed out that the restoration and psychosocial support

happened through face-to-face counselling and support groups. The support groups created platforms for the women survivors to share their experiences and support each other which became sources of strength.

The staff of the NGOs in their interviews revealed several strategies they were employing in trying to combat and respond to IPV. Strategies they spoke about included awareness campaigns, GBV talks, action-oriented campaigns, and *imbizo*. These were meant to prevent IPV from occurring. It also emerged that psychosocial support for those women who had already experienced IPV was being provided. This support was provided through individual counselling sessions, containment counselling, support groups and therapy. Couple counselling, family reconnection and reunification were mostly provided post-IPV to assist the families to restore what had been lost and giving them new coping mechanisms. The NGOs also established that the women survivors of IPV after intervention not only regained their lost power but also regained their ability to collaborate and interact with others, to participate in income-generating activities and, most importantly, regained their self-esteem and confidence. Following this, the women survivors of IPV earned respect and recognition not only within their families but also in the community at large. They were able to assist other women who were still victims of IPV by playing an active part in their families' decision-making processes. Some of the women survivors volunteered in their local NGOs and in doing so were equipped with necessary skills to be employable and, following that empowerment, some were employed. The income they subsequently received improved their families' well-being and their children were well fed and attended school.

The NGOs also revealed the challenges they were facing in providing effective services to their clients. Among other challenges that were mentioned were a lack of funding to keep their projects going, a lack of support from other role players and a lack of proper supervision of staff members. These were said to be their main stumbling blocks.

8.3. STUDY CONTRIBUTIONS

Preceding studies have not paid much attention to the effectiveness of intervention programmes that have been employed for women survivors of IPV in rural contexts such as Msinga. It is acknowledged that while men also experience IPV, the emphasis of this study was on women

due to the intensity of harm that women experience in situations of violence and, by and large, it is women who are most at risk of experiencing IPV. Women's experiences of IPV are influenced by factors such as unequal gender relations which emphasise male dominance and the acceptance of IPV through myths accentuated during the process of socialisation. Using the post-structural feminist theory, this study was able to demonstrate how IPV was experienced by women in Msinga and was a result of the existence of inequalities between men and women in all important spheres of life, discrimination, cultural beliefs, male supremacy and hostility. This illustrates that efforts to address IPV must address the factors that intensify inequalities between men and women and foster discrimination against women. Also needing to be addressed is the abuse that is perpetrated under the false pretence of culture in which male dominance is emphasised.

Therefore, this study's contribution lies in its demonstrating the importance of the implementation of intervention programme initiatives by organisations aimed at addressing the needs of women survivors of IPV in Msinga. It also provides new perspectives in shifts in the preventative modalility in the context of Kwa-Zulu Natal. As revealed in the study's findings, women survivors of IPV indeed faced various challenges in their journey of seeking services from the service providers.

The study also contributed by using Msinga to demonstrate how the cultural environment impacts on the women IPV survivors' services seeking behaviour as well as the support that they were likely to obtain not only from their immediate environment but also from the larger community. It highlights gender-dynamics in the context of culture, health and class. The Msinga community's beliefs dictate that a woman has to be submissive towards her man especially if the lobola has been paid. The women's family would not want to see their children coming back from their marriages because that brings disgrace to the family and it will be assumed that they did not train their daughter properly. To avoid this, women would find themselves enduring abusive male partners.

Another contribution made by the study was that of applying the socio-ecological perspective in the employment of IPV intervention programmes, particularly those offered by the government sector to address the plight of women who had suffered IPV. The study shows the importance of using a holistic approach entailing interventions spanning the continuum from prevention and protection to response and long-term care and support. In most areas, women's

organisations have advocated for new legislation to criminalise various forms of IPV including domestic violence and marital rape. They have also engaged in extensive awareness-raising work at the community level to break the silence surrounding IPV and encouraged women to seek support from the service providers. The results of this advocacy have been varied: some areas now have a fairly comprehensive legislative framework to criminalise IPV (even though in most cases, there is a significant implementation gap); some have policies in the police and justice systems, and the paralegal sectors, to assist apprehension and prosecution; some have medical and nursing staff with improved awareness of IPV; and some have a wider range of counselling and support interventions to assist violated women. However, in areas such as Msinga, response mechanisms are in an elementary state and an effective legal framework does not exist.

South Africa has an array of progressive and internationally competitive laws, programmes and policies that are explicitly intended to protect women from all forms of violence. Key pieces of legislation include, among others, the Criminal Law (Sexual Offences and Related Matters) Amendment Act No 32 of 2007, the DVA No 116 of 1998, and the Films and Publications Amendment Act No 3 of 2009.

The study has contributed by establishing a relationship between women's empowerment and service seeking behaviour. Of importance was how some women dreaded reporting the violence to the police for fear that this would be made known to their partners and hence the possibility of being re-victimised. For those women who completely depended on their male partners for financial supports (and thus food), they were anxious about their inability to support themselves and their children economically in the event that their actions got their partners arrested.

This study has made a notable contribution by showing how NGOs respond in addressing the needs of women who have experienced IPV in Msinga. The study findings revealed that a lack of funding contributed to the NGOs being unable to provide essential services to their clients leaving some of them (clients) in an unsound state health-wise (physically, psychologically and mentally) as well as socially and economically.

Moreover, the study has made a contribution by documenting women survivor's experiences of IPV and how they were able to restore their lives by embracing the intervention programmes

employed by the NGOs to meet their needs. Finally, the study has also demonstrated how women survivors of IPV navigated through such experiences by, for example, drawing support from each other through the support groups that they had formed and from the services provided by the NGOs.

8.4 RECOMMENDATIONS

8.4.1 Recommendations by the participants

Numerous and extensive recommendations were made by research participants on what can be done to reduce IPV against women in Msinga. Their recommendations ranged from encouraging communication between couples in relationships, awareness campaigns and group discussions to action-orientated dialogues and debate forums. These recommendations were meant for men as perpetrators and women as victims or survivors of violence in intimate relationships. It emerged during the interviews that in some situations where partners had differences of opinion, women would often find it difficult to share and communicate their thoughts and feelings. This difficulty was seen as an obstacle in reducing the incidences of IPV. The struggle of solving problems without using violence in intimate relationships also served as an obstacle to decreasing violence in relationships. It became apparent that most men in intimate relationships in Msinga were not aware of other problem-solving methods that could be used and the default was to opt for violence. They barely used communication, respect for one another and understanding as ways of solving problems in their intimate relationships. Their inability to manage their anger increased the possibility that they would resort to violence to solve their problems. The study found that both partners needed to be encouraged to communicate in a relationship.

> "*I personally think communication in relationships be it intimate, family or friendship should be encouraged so that people, in general, can express themselves easily and I strongly believe that can build their self-esteem and violence can be reduced. Women in particular should be encouraged to report matters involving any form of violation to the police and not be scared to do so*." – Cici.

> "*Talking, honesty, and trusting each other are key in relationships because if one thing is missing from those, violence is bound to happen*." – Zothile.

Most participants, including the key informants from the NGOs, indicated that it was important for both partners to respect each other and have a common understanding. They resolutely believed that if male dominance in relationships could be discouraged, IPV could be reduced. They pointed out that since men and women are equal in the eyes of the law, there should be equality in decision-making in intimate relationships as well.

> "*It is imperative to be in love with someone who understands you well and has similar interests to yours in order to avoid unnecessary misunderstandings that can lead to violence in your relationship*." – FGD#1.

> "*Partners need to know and appreciate each other very well so that it can be easy for them to communicate matters better. Trustworthiness is very important for people involved in an intimate relationship; these together prevent violence in relationships*." – FGD#2.

Clearly, open communication should be encouraged to avoid violence in intimate relationships. These were some of the mutual recommendations for the avoidance of IPV raised by almost all the participants in both the in-depth interviews as well as the focus group discussions.

Almost half the women survivors of IPV mentioned that it was imperative to speak out when one was experiencing abuse in a relationship and that one needed to deal with the stigma associated with reporting partner violence. They also indicated that people experiencing IPV needed to have strong sources of support where they could freely talk about their problems without being judged.

> "*I suggest that people need to speak about abuse and their problems in intimate relationships; they can visit service providers dealing with IPV related matters or speak to their trusted associates. If they are severely violated, they can report the matter to SAPS and institutions*." – FGD#1.

A point of discussion was that often both victims and perpetrators of violence found it awkward to seek help when they were experiencing and/or perpetrating IPV because of the stigma that is attached to violence in intimate relationships. It was pointed out by some of the study

participants that both victims and perpetrators of violence should seek help so that relationship issues can be resolved and further violence prevented. Some participants indicated that women need to stand up for themselves and stop being dependent on men for their survival. This was very predominant among women who engaged in relationships with men for economic reasons. They also felt strongly that women should start putting their own needs before those of their partners.

> "*First and foremost, it is essential to know what you want; you must be able to make your own choices and sound decisions without relying on your partner. You must be able to stand up against your partner's violation, show that you do not appreciate the way he treats you because if you do not tell him he will never know and never stops*." – Zamile.

> "*Most women remain in abusive relationships merely because their partners give them money. They love men with money and status, and as long as they have that they really do not mind being beaten up*." – FGD#2.

The women survivors spoke generally on this issue and those who participated in the focus group agreed that women who were financially dependent on their partner were less likely to challenge violence in intimate relationships. This simply meant that some men used both physical and financial power to violate their female partners.

8.4.2 Recommendations by the NGO staff members

The NGO staff who participated in the study were of the view that more education programmes that would deal precisely with violence in intimate relationships and also motivate young men and women to seek help when they were experiencing violence in relationships, both as victims and perpetrators, were needed. This emerged strongly during the focus group discussion and in some of the interviews. The NGO staff further stated that even though they had educational programmes in place, not all staff had access to such information. They thus believed that it was important to have accessible programmes that would address issues of violence in intimate relationships. Such programmes should equip staff with skills, knowledge and information on how to respond to the needs of those experiencing violence in their relationships and how to help them prevent further violence. Staff also believed that these programmes should allow

victims and survivors of IPV to deliberate on the factors contributing to violence between men and women, coach them on how to handle their emotions and to deal with their problems in a non-violent manner.

> "*I think we as workers need group talks where we would be sharing best practice on how to be more effective and efficient in response to IPV related issues. I will be very happy if this can be taken to the next level and not end between you and me or you and other individuals in this discussion room. I will be happy if directors and CEOs can organise such gatherings where maybe all the workers representing the service providers can be present to share how they handle such matters with us*." – FGD#2.

The above points to little having been done to educate staff on issues pertaining to violence in intimate relationships and on how to respond to the needs of the IPV survivors or victims. NGO staff also felt that it was important to have public education programmes in place where the youth of both sexes would be given lessons on how to prevent violence in their relationships as well as how they should treat each other as equal partners.

8.5 IMPLICATIONS OF THE STUDY

The implications of the study are delineated into three categories. Firstly, I present the implications of the findings for IVP policy. Secondly, I deliberate the implications for practice, that is, what the findings suggest for IPV programmes in meeting the needs of women survivors in Msinga. Thirdly, and to conclude, I present the implications of the findings of the study for further research. At this point, I reflect on what this research has done and examine what kind of research is essential in the future.

8.5.1 Implications for IPV policy

It is apparent that IPV is rife in the Msinga community and that it often goes unreported and unpunished. Furthermore, it is usually tolerated and normalised by the community. This research has highlighted the effects of IPV in the Msinga area, and these have critical implications for policy in ensuring that there are violence-free living spaces in the area. A substantial finding of the study was the lack of an effective platform to report IPV and one that deals directly with it. Generally, the study demonstrated how prevailing discourses relating to

IPV in relationships and gender power inequality are essential to the act of IPV in that they encourage male violence and dominance and women's victimisation and passivity. In light of the above, the study recommends the following:

- The Msinga stakeholders who formed part of the study should develop a policy that explicitly highlights the rules and regulations concerning GBV including IPV among women and girls in particular. In the policy, it should be made clear that IPV is forbidden and if women experience it, how and where (including the steps to follow) they can report it. Effort in preventing IPV before it occurs needs to be emphasised more.

- The Msinga community, including the various IPV service providers, are all affected by the historical problem of patriarchy. Henceforth, the entire community needs to promote and ultimately secure gender equality ensuring that the needs of women are at the forefront.

- Also, the Msinga community needs to employ strict rules to eliminate the unfair norms practised under the pretence of culture and love and which are one of the main root causes of violence in the area.

- Policy and programmes addressing the economic determinants of IPV are not well developed in South Africa. An intervention programme with Microfinance for AIDS and Gender Equity (IMAGE) tested the effect of microfinance, combined with a gender- and HIV-training curriculum, on domestic violence in eight villages in Limpopo. The programme was found to lessen domestic violence by 55% in the study sites (Lakey & Cohen 2000). It is suggested that a similar intervention programme, along with the provision of long-term housing, would meaningfully assist abused women in Msinga.

8.5.2 Implications for practice

- The issue of IPV should be recognised through more awareness campaigns and assimilated into all the programmes employed by the service providers in Msinga.

Pamphlets, flyers and posters could be utilised to inform and facilitate discussion both formally and informally.

- During the focus group discussions, it was noted that participants challenged or cheered others in the discussions. This study has shown how participants' ways of making meaning were meaningfully influenced by their interaction with one another. For this reason, peer-led interventions, through conversations, might be an effective tactic for addressing IPV in the Msinga community.

- Influential people such as traditional leadership in Msinga who often interact with the community, government departments, NGOs, CBOs and FBOs should work together in awareness-raising and facilitating discussion on kerbing not just IPV but GBV as a whole.

- Social media is highly influential nowadays. The IPV programme implementers should take advantage of social media and rigorously use them as a means to divulge gender power inequity, gender stereotypes, and partner abuse as demeaning and, therefore, unacceptable.

- Programmes to address the needs of women survivors who have experienced violence can be integrated into existing local systems, including health, education and legal systems. For example, a recent health sector response to IPV in low- and middle-income countries discovered models of integration that are being replicated in many settings, often focusing on service provision at the secondary or tertiary level of healthcare. These services are offered through emergency or women's health services and at a primary level through reproductive or family planning services (Colombini et al 2008; WHO & London School of Hygiene and Tropical Medicine 2010).

- Last but not least, the SAPS with the support of traditional authorities who are more trusted by the community should be thoroughly capacitated, equipped and mentored on how to handle IPV cases and be more proactive in helping women when approached. In addition, they should undergo training regarding gender-sensitive matters and professionalism in the workplace. Failure to conduct themselves according to their

training would need to be ruthlessly dealt with, with dismissal being the ultimate sanction. Moreover, SAPS should do patrolling more often in the Msinga area.

Merging primary, secondary and tertiary prevention strategies would be best particularly in communities where families are already characterised by violence. The socio-ecological model establishes how people may be at risk of experiencing or perpetrating violence and deliberates the complex interplay between individual, relationship, community, and societal factors. Comprehensive prevention strategies that address the various levels of the model have the greatest potential for impacting change. The study endorses improved collaboration among the stakeholders involved in responding to the needs of women survivors of IPV in Msinga. Breakdowns in the provision of services only serve to disrupt individual or institutional intervention efforts. Priority should be given to efforts that aim at preventing IPV through a multisectoral approach (involving government, NGOs, researchers, CBOs, traditional leaders and donors) instead of intervening after violence occurs. This would involve programmes that aim at addressing the causes of IPV and those that aim at promoting gender equality in all the vital spheres of life – social, economic and political.

Competition amongst stakeholders should thus be discouraged since they all aim at achieving a similar goal, namely, alleviating the suffering of women who have experienced IPV. Organisations should learn to complement each other to achieve greater results.

8.5.3 Implications for further research

I recommend that further study concerning GBV, particularly IPV, be conducted in other rural areas in South Africa as research concerning IPV in such contexts is limited. Research should mainly focus on IPV, cultural practices, power and inequality in relationships, IPV reporting issues and security issues all of which play a substantial role in the perpetration of IPV. Furthermore, other forms of IPV such as emotional, social and financial abuse need to be highlighted in future research endeavours.

The study focused on women survivors of IPV. However, some men experience IPV. There is thus a need for more research that focuses on men's experiences and their ways of coping. It would be fascinating to determine how gender influences the type of intervention programmes

put in place and what men's responses are to intervention programmes geared towards addressing their needs following IPV.

There is also a need for research on the experiences of children who have witnessed IPV. Given the possibility that some have transitioned to adulthood, it would be equally fascinating to learn from them regarding how they have moved through their stages of development into adulthood, the challenges they have faced, how they have overcome them, how they would wish their needs to be addressed and whether they have learnt any lessons drawn from the experiences of their parents.

The above will assist in informing both policy and practice and for policy to be employed in a more informed manner to, ultimately, make rural areas secure and friendly living spaces.

8.6 CONCLUSION

This research was qualitative in nature and aimed at examining the effectiveness of programmes being implemented to address the needs of women experiencing IPV in Msinga, KZN, South Africa. I have presented findings which suggest that IPV in Msinga is rife, with women, in particular, suffering it daily. The women participants' responses emphasised that socialisation contributes significantly to how they conduct themselves in their intimate relationships often habitually accepting abusive behaviour for the sake of maintaining relationships. This study believes anti-GBV activists, feminists and the Msinga community need to ensure that women are knowledgeable about IPV and, therefore, are able to make well-informed decisions concerning the actions they should take should they experience it.

In conclusion, it is vital for all service providers who are involved in addressing IPV against women to examine their own prejudices regarding this social challenge. These service providers should be more than willing to educate themselves by listening attentively to the IPV survivors' and victims' stories instead of imposing their own interpretations, beliefs, and assumptions on them. They need to acknowledge that ending IPV is not the responsibility of the victim but rather that of the perpetrator. It is imperative to understand that a cultural change needs to transpire in the language used when assessing and offering services to survivors and victims of IPV and in the strategies used to address it. The actual question to be answered is not "Why does the victim stay?" but rather "Why does the perpetrator not let the victim leave?"

It will only be when the emphasis on IPV is moved to the perpetrator (and not the victim) that solutions will be found.

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APPENDICES

Appendix 1: Ethical clearance certificate

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

25 July 2019

Ms Cynthia Sanelisiwe Ndlovu (204518517)
School of Applied Human Sciences
Pietermaritzburg Campus

Dear Ms Ndlovu,

Protocol reference number : HSS/0196/019D
Project title: Examining the effectiveness of programmes being implemented to address the needs of women experiencing intimate violence in Msinga, KwaZulu-Natal, South Africa

Approval Notification – Expedited Application
With regards to your response received on 12 June 2019 to our letter of 19 May 2019, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has 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 1 year 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

[redacted]
Dr Rosemary Sibanda (Chair)

/ms

cc Supervisor: Dr Janet Muthoni Muthuki
cc Academic Leader Research: Professor Ruth Teer-Tomaselli
cc School Administrator: Ms Priya Konan

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:** xmbap@ukzn.ac.za / snymanm@ukzn.ac.za / mchuma@ukzn.ac.za
Website: www.ukzn.ac.za

Appendix 2: Gatekeepers' letters

SINOZWELO RESOURCE CENTRE

PROVINCE OF KWAZULU-NATAL

ISIFUNDAZWE SAKWAZULU-NATAL

PROVINSIE KWAZULU-NATAL

TEL:

17.09.2018

Sinozwelo Resource Centre

Esidakeni Area

Tugela Ferry

3010

RE: PERMISSION TO CONDUCT RESEARCH

Dear Ms. L S Ndlovu

Gatekeeper's permission is hereby granted for you to conduct research at Sinozwelo Resource Centre towards your postgraduate studies, provided ethical clearance has been obtained. We note the title of your research project is:

"Examining the effectiveness of programmes being implemented to address the needs of women experiencing intimate partner violence in Msinga, KwaZulu-Natal, South Africa."

We would like to take this opportunity and wish you best of luck in the whole research process as we understand that this will also add value in our daily work.

Yours sincerely

Ms. Nokwanda Zondo

Social Worker

[redacted]

SINOZWELO RESOURCE CENTRE

LifeLine
Pietermaritzburg

Rape Crisis

LifeLine and Rape Crisis

76 Harding Street, PO Box 2075, Newcastle

2300

RE: PERMISSION TO CONDUCT RESEARCH

Dear Ms. C S Ndlovu

Gatekreeper's permission is hereby granted for you to conduct research at LifeLine Crisis Centre in Church of Scotland hospital in Msinga towards your postgraduate studies, provided ethical clearance has been obtained. We note the title of your research project is:

"Examining the effectiveness of programmes being implemented to address the needs of women experiencing intimate partner violence in Msinga, KwaZulu-Natal, South Africa."

We also understand that you will engage with our clients on one on one interviews and later you facilitate a focus group. Please bear in mind that this may trigger some pains to our clients thus, we suggest that all the interviews be done in the morning while we are still in the full force to provide extra support to those who may need it.

We would like to take this opportunity and wish you best of luck in the whole research process as we understand that this will also add value in our daily work.

Should you need any clarification please do not hesitate to contact the undersigned on 033 342 4447

Yours sincerely

Ms. Nokulunga Magubane

GBV Manager

[redacted]

KHAYELISHA CARE PROJECT

"To give love, hope and a future to every child"

P.O Box 310 Tugela Ferry
Kwa-Zulu Natal 3010

Tel 033 493 0078
khayelishacare@asinet.co.za

17/09/2018

Dear Ms. C.S Ndlovu

RE: PERMISSION TO CONDUCT RESEARCH

Permission is hereby granted for you to conduct research at KHAYELISHA CARE PROJECT towards your postgraduate studies, provided ethical clearance has been obtained. We undertake to assist with the identification of subjects to be interviewed and introduce you to these individuals. We hold you to your undertaking to not identify any of your interviewee's during or after your studies.

We note the title of your research project is:

"***Examining the effectiveness of programmes being implemented to address the needs of women experiencing intimate partner violence in Msinga, KwaZulu-Natal, South Africa***"

We would like to take this opportunity and wish you best of luck in the whole research process as we understand that this will also add value to our daily work.

Yours sincerely

[redacted]

Lizeth M
Manager

KHAYELISHA CARE PROJECT

PO Box 110
Pomeroy
3020
17.09.2018

RE: PERMISSION TO CONDUCT RESEARCH

Good Day Ms. Ndlovu

It is with our pleasure to inform you that the gatekeeper's permission is hereby granted for you to conduct research at Umusa wolMinga project under Noyibazi Clinic towards your postgraduate studies, provided ethical clearance has been obtained. We also note the title of your research project is:

"***Examining the effectiveness of programmes being implemented to address the needs of women experiencing intimate partner violence in Msinga, KwaZulu-Natal, South Africa.***"

The details of the research are understood to be as per letter provided by the researcher and her supervisor.

Umusa woMsing project takes this opportunity of wishing you everything of the best with your study.

Yours sincerely

Sr Bongiwe Thusi

Sister in Charge

[redacted]

Appendix 3: Informed consent

Informed Consent Document

Dear Participant,

My name is Sanelisiwe Ndlovu (*204518517*). I am a PhD candidate studying at the University of KwaZulu-Natal, Pietermaritzburg Campus. The title of my research is: "Examining the effectiveness of programmes being implemented to address the needs of women experiencing intimate partner violence in Msinga, KwaZulu-Natal, South Africa". The aim of the study is to broadly examine the effectiveness of programmes being implemented to improve the survival of women experiencing IPV in Msinga. It will make excessive contributions in documenting the organizations' responses to IPV in Msinga and to add to the body of knowledge on the understanding of using prevention strategies in responding to IPV and to strengthen the intervention programmes. I am interested in interviewing you so as to share your experiences and observations on the subject matter.

Please note that:

- The information that you provide will be used for scholarly research only.
- Your participation is entirely voluntary. You have a choice to participate, not to participate or stop participating in the research. You will not be penalized for taking such an action.
- Your views in this interview will be presented anonymously. Neither your name nor identity will be disclosed in any form in the study.
- The interview will take about 45 minutes to an hour.
- The record as well as other items associated with the interview will be held in a password-protected file accessible only to myself and my supervisors. After a period of 5 years, in line with the rules of the university, it will be disposed by shredding and burning.
- If you agree to participate please sign the declaration attached to this statement (a separate sheet will be provided for signatures)

I can be contacted at: School of Social Sciences, University of KwaZulu-Natal, Pietermaritzburg Campus Scottsville. Email: sanelisiwen@youthkzn.co.za.; Cell: 071 1684 737
My supervisor is Dr. Janet Muthuni Muthuki who is located at the School of Social Sciences, Pietermaritzburg Campus of the University of KwaZulu-Natal. Contact details: email Muthuki@ukzn.ac.za; Phone number: 033 2606 462.

The Humanities and Social Sciences Research Ethics Committee contact details are as follows: Ms. Phumelele Ximba, University of KwaZulu-Natal, Research Office, Email: ximbap@ukzn.ac.za,Phone number +27312603587.

Thank you for your contribution to this research.

1

DECLARATION

I..... *(full names of participant)* hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the project at any time, should I so desire. I understand the intention of the research. I hereby agree to participate.

I consent / do not consent to have this interview recorded (if applicable)

SIGNATURE OF PARTICIPANT DATE

.....

2

Incwadi Yemvume

Sawubona,

Igama lami ngingu Sanelisiwe Ndlovu (*204518517*). Ngenza iziqu zebunga eliphezulu eNyuvesi yaKwaZulu Natali eMgungundlovu. Isihloko sophenyo lwami sithi: "Ukuhlola ukusebenza kwezinhlelo zokubhekana nezidingo zabantu besifazane ababhekene nokuhlukunyezwa ngabalingani babo endaweni yase Msinga, KwaZulu Natali eNingizimu Afrika" Inhloso yalolu phenyo ukuhlolisisa kabanzi ukuthi ngabe izinhlelo zokuiwa nokuhlukumezwa kwabantu besifazane la eMsinga ziyalunyusa yini izinga lokuphila kwabo abesifazane. Luzophinda luthi lungeze kabanzi ulwazi nokuqonda ngezindlela ezihlukene zokuvimba lokho kuhlukumezeka kanye nezindlela zokuthiba ukubhekana nokuhlukumezeka kwabesifazane. Ngimesifiso esikhulu sokuphenya wena usho uvo lwakho nokunye oke ukubone kwenzeka unayelana nalolu daba esikhuluma ngalo.

Ngicela uqaphele lokhu:

- Ulwazi ozolulethe la lizosetshenziswa kwisikole sophenyo kuphela.
- ukuzibandakanya kwakho akuphoqiwe. Unelungelo lokunqaba ukuzibandakanya okanye uphume phakathi nalo uphenyo. Ngeke ujeziswe ngulokho.
- Imibono yakho kulolu phenyo izothulwa ngekwemfihlo. Ngeke amagama akho okanye uhlobo lwena buchazwe kuzo zonke izigaba.
- Uphenyo luzothatha imizuzu cyamashumi amane nanhlanu kuya kwi lihora elilodwa.
- Isiqophi ajengoba siyingxenye yophenyo naso, sizoba sezandleni zami no msekeli wami kuphela futhi kuzoba nezinombolo zokugcina imfihlo equkethwe yiyo. Enye keminyaka emihlanu, naqondana nemithetho yaseNyuvesi, izobe isihleshulwa bese ishiswa.
- Uma uvuma ukuba ingxenye yalolu phenyo ngizocela angishexilela lemvume efakwe kule ngxoxo (iphepha elihlukile lifakiwe ukuze ushixilele)

Mina ngitholakala eSikoleni seSocial Sciences, eNyuvesithi yaKwaZulu Natali, eMgungundlovu, Email: sanelisiwendlovu@youthkzn.co.za ;
Inombolo engithulakala kuyo: 071 1684 737
Umsekeli wami uDokotela Janet Muthoni Muthuki naye utholakala eSikoleni seSocial Sciences, eMgungundlovu eNyuvesi yaKwaZulu Natali. Izindlela zokuxhumana: email Muthuki@ukzn.ac.za; Ucingo: 033 2606 462.

Izindlela zokuxumana nekomidi lukwa "*Humanities and Social Sciences Research Ethics Committee*" zimi kanje: Nkosazane. Phumelele Ximba, Nyuvesi yaKwaZulu Natali eUkhovisi lezophenyo. Email: ximbap@ukzn.ac.za, Ucingo +27312603587.

Ngiyabonga uguxhaso lwakho kulolu phenyo.

IMVUMO

Mina..... *(umagama aphelele welunga lophenyo)* ngiyaqinisekisa ukuthi ngiyawuqonda umsuka kanye nenjongo yalolu phenyo, futhi ngiyavuma ukuba ngibe ingxenye yophenyo.

Ngiyaqonda nginelungelo lokushiya kulelu phenyu noma inini uma ngifisa. Ngiyaziqonda izinjongo zalolu phenyo. Ngakho ke ngiyavuma ukuba ingxenye.

Ngiyavuma / angivumi ukuba lolu phenyo luqoshwe. (uma kunesdingo)

ISISHIXILELI SOYINGXENYE YOPHENYO USUKU

.....

Appendix 4: Interview guides

INTERVIEW GUIDE FOR MANAGERS/COUNSELLORS WORKING WITH IPV ORGANISATIONS

1. What is the extent of intimate partner violence (IPV) in Msinga?
2. What is your own experience in providing IPV services to the survivors and victims of IPV?
3. What challenges have you faced as a result of providing services to the IPV survivors?
4. What kind of services you provide to the IPV survivors as an organisation?
5. What strategies does the organisation use to address the needs of the survivors of IPV?
6. What effect have these strategies had on dealing with IPV?
7. What are the ways in which your organization has succeeded in addressing IPV?
8. What are the ways in which your interventions have not been successful in assisting survivors of IPV?
9. How does your organisation engage with gender based violence policies to address the needs of survivors of IPV?
10. What challenges have you faced in implementing these gender policies?
11. What are the ways in which you think the organization can improve on its strategies in assisting survivors of IPV?
12. What would be your recommendation for the improvement and implementation GBV policies?

FOCUS GROUP DISCUSSION GUIDELINE FOR THE IPV PROGRAMME IMPLEMENTERS

1. What are the programmes implemented at Msinga in addressing issues of IPV?
2. What impact have IPV programmes had on women and the community as a whole?
3. What do you think should be done to curb IPV against women rather than what you are already doing?
4. What are challenges faced when providing services to women survivors of IPV in your community?
5. What other services do you think can be provided to survivors of IPV?
6. Which new strategies can be used to address IPV in this community?
7. What recommendations do you make in the provision of IPV services in accommodating the needs of women survivors of IPV?

INTERVIEW GUIDE FOR INDIVIDUAL WOMEN SURVIVORS OF INTIMATE PARTNER VIOLENCE

1. What is the extent of IPV in Msinga?
2. What is your own experience of intimate partner violence?
3. What challenges have you faced as a result of IPV?
4. How has your life been affected by IPV?
5. How did you get to know about organisations providing support for IPV survivors?
6. What kind of services have you received from the said organisations?
7. How would you describe the services rendered to by the organisations that are dealing with IPV in Msinga?
8. What strategies does the organisation use to address the needs of the survivors of IPV?
9. What effect have these strategies had on your experience of IPV?
10. What are the ways in which you think that the organization has succeeded in addressing IPV?
11. What are the ways in which their interventions did not succeed in assisting your case?
12. What are the ways in which you think the organization can improve on its strategies in assisting survivors of IPV?

UHLA LEMIBUZO LOPHENYO LABANTU NGABANYE BESIFAZANE ABABHEKENE NOKUHLUKUNYEZWA ABANTU ABATHANDANA NABO

1. Lingakanani izinga lengxabano phakathi kwabantu abathandanayo eMsinga?
2. Ithini imizwa yakho ngokuhlukumezana phakathi kwabantu abathandanayo?
3. Iziphi iziqinamba obhekene nazo njengomphumela wokuhlukunyezwa ngothandana nayo?
4. Kube imuphi umthelelo obe khona empilweni yakho ngenxa yokuhlukunyezwa othandana naye?
5. Waze kanjani ngezinhlelo ezikule nhlangano zokulwisana nokuhlukumezaka kwabesifazane behlukumezwa abathandana nabo?
6. Iluphi usizo osuluthollile kule nhlangano olusizayo kubantu besifazane abahlukunyezwa abathandana nobo?
7. Ungaluchaza kanjani usizo olutholile kulolu hlelo lokulwisana nezimo zokuhlukumezana kwabantu abathandanayo eMsinga?
8. Iziphi izinhlelo inhlangano enazo ekulwisaneni nokuhlukumezaka kwabantu besifazane abahlukunyezwa abantu abathandana nabo?
9. Zinamuphi umthelelo lezi nhlelo zokulwisana nezimo zokuhlukunyezwa kwabantu besifazane ngabantu abathandana nabo?
10. Iziphi izindlela ocabanga ukuthi izinhlelo zokulwisana nokuhlukumezeka kwabantu besifazane behlukunyezwa abathandana nabo zibe impumelelo?
11. Iziphi izindlela ocabanga ukuthi izinhlelo zokulwisana nokuhlukumezeka kwabantu besifazane behlukunyezwa abathandana nabo azibanga impumelelo?
12. Iziphi izindlela ocabanga ukuthi kumele inhlangano noma uhlelo izingeze ukuze kunyuke usizo lokusiza abantu besifazane ababhekene nokuhlukunyezwa abantu abathandana nabo?

FOCUS GROUP DISCUSSION GUIDELINE FOR WOMEN SURVIVORS OF IPV

1. What do you understand by the term intimate partner violence (IPV)?
2. What are the causes of IPV against women in your community?
3. What impact has IPV had on women and the community as a whole?
4. What do you think should be done to curb IPV against women?
5. What are challenges faced when dealing with IPV against women in your community?
6. How did you become aware of organisations dealing with IPV?
7. What kind of services have you received from these organisations?
8. What has been the effect of these services in dealing with IPV?
9. What other services do you think can be provided to survivors of IPV?
10. Which strategies can be used to address IPV in the community?

INKULUMO YABANTU BESIFAZANE ABAHLUKUNYEZWA ABANTU ABATHANDANA NABO

1. Yini ukuqonda kwakho ngokuhlukumezeka okuphakathi kwezithandani?
2. Ngabe iziphi izimbangela ezenza abantu besifazane bahlukunyezwe abantu abanobudlelwano nabo kulo mphakathi?
3. Umuphi umthelela okhona ngokuh ukumezaka kwabantu abathandanayo kubantu besifazane kulo mphakathi wonkana?
4. Ucabanga ukuthi yini okumele kwenziwe ukuze kubhekwane nesimo sokuhlukumezeka kwabantu abathandanayo?
5. Iziphi izingqinamba abantu besifazane ababhekene nazo uma kuliwa nezimo zokuhlukunyezwa kwabo ngabantu abathandana nabo kulo mphakathi?
6. Waze kanjani ngezinhlelo zamaqembu alwisana nezimo zokuhlukumezana kwabantu abathandanayo?
7. Uluphi usizo usuke waluthola kuzinhlelo zale nhlangano?
8. Ngabe usizakale kanjani ngezinhlelo ozitholile kule nhlangano yokuqoba ukulwa nokuhlukumezeka kwabantu abathandanayo?
9. Iziphi ezinye izinhlelo ocabanga ukuthi kumele zinikwe abantu besifazane ababhekene nokuhlukunyezwa abantu abathandana nabo?
10. Iziphi izinto ezingenziwa ukulwisana nokuhlukumezeka kwabantu abathandanayo kulo mphakathi?

Appendix 5: Proof of editing letter

Athol Leach (Proofreading and Editing)

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16 January 2021

To Whom It May Concern

This letter serves to confirm that I have edited the following PhD (Gender Studies) dissertation by
Cynthia Sanelisiwe Ndlovu
Student number: 204518517

EXAMINING THE EFFECTIVENESS OF PROGRAMMES BEING IMPLEMENTED TO ADDRESS THE NEEDS OF WOMEN EXPERIENCING INTIMATE PARTNER VIOLENCE IN MSINGA, KWAZULU-NATAL, SOUTH AFRICA.

The dissertation was edited in terms of grammar, spelling, punctuation and overall style. In doing so use was made of MS Word's "Track changes" facility thus providing the student with the opportunity to reject or accept the changes made.

Please note that while I have checked the in-text references for consistency in terms of format, I have not done so with the references in the list of references. Neither have I checked the veracity of the sources themselves or that the bibliographic information is complete.

Please further note that this editing was done prior to submission of the dissertation to Turnitin and I have not been involved in any changes that may have been made subsequent to this.

The tracked and final document is on file.

Sincerely

[redacted]

Athol Leach

(MIS, Natal)