

**Development of strategies to empower women against intimate partner violence
occurrences in Vhembe District, Limpopo province.**

By

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Department of Public Health.**

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DECLARATION

I, NETHAVHANI LILIAN, hereby declare that this thesis for Doctor of Philosophy in Public Health titled “**Development of strategies to empower women against intimate partner violence occurrences in Vhembe District, Limpopo province**” submitted to the school of Health Sciences at the University of Venda has not been submitted previously for any degree at this or another University or Institution. It is original in design and execution, and all reference materials contained herein are appropriately acknowledged.

Signature  Date 2023/07/24

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(PreCCL) strategies to empower women against intimate partner violence in Limpopo Province, South Africa. PreCCL strategies were developed based on qualitative and quantitative IBM (Information, Motivation and Behaviour) of IPV results as well as evidence-based information from the review of the literature.

ABSTRACT

Violence against women in South Africa is regarded as a national emergency. Although the national picture reflects a decrease of 69.4% from 9 990 cases between 29 March and 22 April 2019 to 3,061 since the lockdown until 20 April 2020, with a difference of 6,929, these statistics are still worryingly high because one death is too many. This study developed strategies to empower women against intimate partner violence occurrences in the Vhembe district. The study was divided into two phases, Phases 1 and 2. Phase 1 utilised an explanatory sequential mixed methods design with quantitative data collected first, followed a qualitative to explore the issue further.. The mixing of results occurred during the interpretation of the results. For the quantitative strand, the census sampling technique was used with a sample of 792 domestic violence victims. A non-probability purposive/judgmental sampling method was used to select 25 participants for the qualitative strand. Quantitative data gathered using questionnaires was entered into the Statistical Package for Social Sciences version 27 software and analysed using descriptive statistics. and The results were presented in frequency table and charts. Qualitative data was analysed with interpretative phenomenological analysis with the aid of Atlas it8. The findings of the study were that: most of the women knew what IPV is, its forms, causes, and factors as well as resources available to the victims. The findings on knowledge component regarding safety planning and legal route present showed that the majority did not know the safety planning preventative measures that they can use to prevent their partners from harming them. The X^2 (315.861a; $df = 6$; $N = 685$; $p = 0.000$) results revealed a significant association between the use of legal route and religious affiliation of respondents. The intervention strategies were developed from the findings and then validated for relevance and acceptance by the stakeholders. The study concluded that the state of IPV intervention strategies in the province of Limpopo was ineffective in addressing the persistent IPV problems in the communities. The study recommended that the Department of Health, Justice and Social Development as well as victim empowerment centres dealing with IPV adopt and implement the developed intervention strategy and engage NGOs, NPO's, faith-based organisations and other stakeholders for support to roll it over in one sub-district to assess its effectiveness and ensure that they revisit and review the counselling materials and ensure that facilities are offering support to perpetrators and victims.

Keywords: Development, Empowerment, Intimate, Knowledge, Partner, Strategy, Violence.

LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immuno Deficiency Syndrome
DV	Domestic Violence
CEDAW	Committee on the Elimination of Discrimination Against Women
IMAGE	Intervention with Microfinance for AIDS & Gender Equity
IMB	Information motivation and behaviour
IPA	Interpretative phenomenological analysis
IPV	Intimate partner violence
IPVAW	Intimate partner violence against women
IVEP	Integrated Victim Empowerment Policy
FV	Family Violence
GBV	Gender-based violence
HIV	Human immunodeficiency virus
LGBTI	Lesbian gay bisexual transgender intersex
OMC	One Man Can
HWC	Health-care worker
PreCCL	Preventive, community-based, corrective and law enforcement
SABC	South African Broadcasting
SAPS	South African Police Services
SEA	Sexual exploitation and abuse
SPSS	Statistical Package for the Social Sciences
TVEP	Thohoyandou Victim Empowerment Programme
VEP	Victim Empowerment

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CHAPTER 1

INTRODUCTION AND BACKGROUND

1.1 Introduction

According to the World Health Organization (WHO) (2013), intimate partner violence (IPV) encompasses “physical violence, sexual violence, stalking, and psychological abuse by a current or former intimate partner.” IPV affects millions of women, men, and children, and can have serious physical and psychological health consequences for individuals, communities, and society (McKeown & Harvey, 2018). Some of the common terms used to describe IPV are courtship battering, spouse abuse, domestic abuse, marital rape, and date rape (WHO, 2016). The IPV also includes acts of physical aggression such as hitting or kicking, violence by intimate partners, forced intercourse and other forms of sexual coercion, and psychological abuse such as humiliation, intimidation, as well as controlling behaviour (WHO,2016). This chapter is structured in subsections namely the background to the problem, the problem, rationale, aim and objectives, benefits of the study, definitions of concepts and theoretical framework.

1.2 Background to the problem

IPV is a serious yet preventable public health challenge globally. It inevitably occurs within an intimate relationship where both perpetrator and victim are known to each other and have either been or are still in an intimate relationship of some sort (WHO,2016). IPV occurs in all countries around the world with differing rates of prevalence and it affects mostly women (WHO, 2016). Recent global estimates suggest that the global prevalence of physical and/or sexual IPV among all ever-partnered women was 30.0% in the year 2013 (WHO, 2013). The prevalence was highest in South-East Asia, Africa and East Mediterranean regions, with close to 37% of women with regular partners who have been exposed to physical and/or sexual IPV (WHO, 2013). Similarly, the Americas region has substantial reports of IPV prevalence in which close to 30% of women indicated to have experienced some abuse or violence due to intimate partners. IPV prevalence reports seem to be relatively low in the high-income regions such as Western Pacific with 23% and Europe having 25% cases for long-time partnered women during their lifetime (WHO, 2013). A survey conducted in the United States (US), indicates that at least one in four women in the United States reports having experienced domestic violence (DV) in her lifetime.

A study by Bloom and Tavrow (2018) shows that women were common across ages, occupations, socioeconomic levels, ethnicities and religions have at some time during time suffered abuse from their intimate partners. In Australia, the latest statistics indicate that one in four women did experience emotional abuse from a previous or current partner and one in six women has experienced physical violence (Briggs, 2018). IPV is common throughout most sub-Saharan African countries, with the rate of abuse close to 36%, a figure way above 30% of the global average (WHO, 2013). Many women in Africa are subjected to lifetime partner violence (45.6%) and sexual assault (11.9%) than women anywhere in the world (WHO, 2013). Although there is no single reporting or surveillance system in place to measure IPV, population-based surveys conducted across Africa suggest that it is prevalent and violent. Reports from studies conducted in Botswana show higher levels of IPV against women with a lifetime frequency IPV prevalence of 50% (Bloom & Tavrow, 2018). Another survey in Tanzania shows that 35.8% of women reported having been subjected to sexual, physical and/or psychological IPV within the last twelve months (Mulawa, Kajula, Yamanis, Balvanz, Kilonzo & Maman, 2016). The same applied to Namibia where more than a third of women were subjected to sexual or physical violence by their intimate partners (Bikinesi, Mash, & Joyner, 2017). These forms of IPV persistently occur among women of all ages including pregnant ones. According to Bikinesi, Mash and Joyner (2017), close to 50% of the pregnant women reported having been severely physically through fist punches or being kicked in the abdomen, while more than 90% of the IPV cases were committed by male partners responsible for the pregnancy. It is argued that the reported prevalence of IPV could be higher, however, due to underestimation, underreporting and poor standardization of methods it is low (Spencer, Haffejee, Candy, & Kaseke, 2016).

Empowerment of women against domestic violence by their intimate partners has been on the international agenda (Ellsberg, Arango, Morton, Gennari, Kiplesund, Contreras, & Watts, 2015). Several laws and policies have been introduced to tackle violence against women. Many African countries have signed and also ratified various international conventions (Beijing Platform for Action [BPFA], 1995; UN Resolution 1325 on Women, Peace and Security, 2000; and the Protocol to African Charter on the Human and People's Rights on the Rights of Women in Africa, 2003) as a sign of commitment in eradicating gender-based violence in their own countries. The 1st generation of interventions focused mainly on the provision of support services for the survivors of the violence and sought to decrease and reduce perpetrators' impunity and increase as well as strengthen the effectiveness of the justice system (Ellsberg, Arango, Morton, Gennari, Kiplesund, Contreras, & Watts, 2015). The 2nd generation of

programming, mainly in middle-income as well as low-income countries, has had a greater focus on violence prevention. These include skills building and economic empowerment programming, community mobilisation, sophisticated education-entertainment or so-called edutainment programmes, large-scale campaigns, as well as participatory group education efforts, with the aim of changing attitudes and norms that support violence against girls and women, empowering girls and women economically and socially, and promote non-violent, gender-equitable, behaviours (Ellsberg, Arango, Morton, Gennari, Kiplesund, Contreras, & Watts, 2015). However, despite these empowering interventions, IPV seems to be rising globally, including in South Africa.

South Africa is not immune to IPV occurrences. According to S Africa Demographic and Health Survey (2016), one in five women older than 18 experienced physical violence despite the implementation of the victims' empowerment programme and the progressive reforms in the constitution, and legal system. This figure is reportedly higher in the poorest households, where at least one in three women reported physical violence. South African Police Services (SAPS) indicates a 7.7% rise in femicide, with a dramatic increase of women murders from 9.6% in 2015 to 20.8% in the year 2016/17(SAPS,2019). Furthermore, the SAPS crime statistics report of 2018 shows that 50 108 sexual offences cases were reported in 2017/8, which is a 0.9% increase from the previous year, the femicide increased by 11% over the previous two years (SAPS, 2019).

Vhembe district is one of the five districts in Limpopo province of South Africa and has a high number of IPV cases recorded. Data from the provincial justice department shows that the Vhembe district reported the highest prevalence of domestic violence in the Limpopo province (Department of Justice, 2020). More than 12000 cases of domestic violence are reported in Vhembe annually (Department of Justice 2020). According to Thohoyandou Victim Empowerment Programme (TVEP), cases of domestic violence have increased, and they record an average of 120 new cases every month (Thohoyandou Victim Empowerment Centre, 2019). The cases include women who are verbally, emotionally and physically abused by their partners. In addition, there are also sudden increases in rape and ritual killings. About 40 cases of rape and six ritual murders were reported in the Vhembe district (Thohoyandou Victim Empowerment Centre, 2019).

Data collected from trauma centres in the district shows that in 2013 alone about 2553 cases of IPV were reported in the first quarter of 2012/13 (Gender Links, 2012). Further data from a

survey by Gender Links in Limpopo province including Vhembe province indicates that more than three quarters (77%) of the women experienced some form of gender-based violence at least once in their lifetime compared to 48% of men who perpetrated VAW at least once in their lifetime, about half of the women (51%) experienced while 44% of men perpetrated intimate partner violence, 31% of women experienced whilst 36% of men perpetrated emotional IPV in their lifetime, about a quarter (23%) of women experienced while 25% of men perpetrated physical IPV in their lifetime, 13% women experienced and 14% men perpetrated economic IPV in their lifetime, 7% women experienced and 12% men perpetrated sexual IPV in their lifetime. One in every five (21%) women with children reported abuse during pregnancy, 5% of women reported being raped while 23% of men have committed rape of a non-partner in their lifetime and 66% of women who work reported that they had been sexually harassed in the workplace (Gender Links, 2012).

The higher incidence of gender-based violence cases in the Vhembe district is attributed to the fact that it is a rural district where patriarchal views of the family are common. In this part of the country, several males are socialised early in their boyhood stages to accept gender discrimination, gender-based violence and gender inequality and this leads them to grow up believing ill-treating children and women is an acceptable practice (Sonke News, 2011; Thobejane, Luthada & Mogorosi, 2018). As in many other communities, cultural, religious and these strong traditional practices expose women and children to different forms of violence developing tendencies among men that women should be obedient and submissive (Sonke News, 2011; Ahikire, 2014). In many cases, “culture” is used to justify the abuse, although some traditionalists tend to disapprove of it while expecting children and women to adhere to traditional culture by respecting it (Thobejane, Mogorosi & Okere, 2017).

Literature shows that such factors reduce the ability of several women to openly speak about the abuse they face or witness and this reinforces the traditional beliefs that husband and wife must keep what happens between them a private matter (Gender Links, 2012; Riddell, Ford-Gilboe, & Leipert, 2008). This social structure in traditional communities encourages men to use violence as a tool for social control against women and children (Ahikire, 2014; Gagne, 1992). Furthermore, rural communities are reported as being very socially cohesive, pretending to be agreeing on values, causing them to be immune to cultural diversity (Amadiume, 2015). Women living in rural communities in many cases more likely to cherish and uphold such bad beliefs and values and subsequently become so hesitant to divulge IPV, seek help, or leave the relationship (Baloyi, 2017).

As a result, in the Vhembe district girl children and women live with the certainties of sexual violence during the course of their lives and with minimal help or/and action from men to stop the abuse (Thobejane, Mogorosi & Okere, 2017; Sonke News, 2011). Women who make attempts to provide assistance to the victims of sexual violence are usually intimidated or threatened by men (Riddell, Ford-Gilboe & Leipert, 2008). According to Mshweshwe (2018) women who live in rural and regional areas always experience many challenges when want to leave violent relationships. The majority of women living in rural areas are more likely to be isolated and have to travel long distances to get support from family and friends and to access formal police and domestic violence support services (Tshifhumulo, Thobejane & Chimeri, 2018). Access to medical assistance, health and counselling services is limited in rural areas compared to major cities. Offenders or victims may be widely known in rural or regional communities (Thobejane, 2019). In many cases, marriages limit woman's right to their sexual reproduction as they are expected to have children, but have no say in the number of children they give birth to as this is determined by husbands and in-laws who expect and demand raising of large families (Baloyi, 2017). Worse still, a woman who fails to conceive is subjected to a host of abuses by in-laws who may force men to marry a second wife or have extramarital affairs with other women to have (Baloyi, 2017).

The South African Domestic Violence Act No. 116 of 1998 makes provision for the protection of women against domestic violence. However, this societal problem does not seem to be near abating in the country. Bower (2014); Chuma and Chazovachii (2012) observe that although the Domestic Violence Act no116 of 1998 demonstrates some real progress in dealing with the problem of domestic violence in S Africa, rural areas still face challenges. People have been critical of the Act because no progress and efforts have been made in making rural communities access the criminal justice system (Artz, 2010; Mshweshwe, 2018). Since the promulgation of the Act, rural women seem to have not benefited because they still found it very difficult to access assistance and support concerning IPV issues, highly prevalent within their communities (Bower, 2014; Davhana-Maselesele, Myburgh & Poggenpoel, 2009). To further worsen the problem, most rural areas including Vhembe, continue to be deprived of empowerment services such as counselling, domestic violence awareness campaigns and shelters (Bower, 2014; Mshweshwe, 2018).

Initiatives to raise awareness about IPV have been reported to be an area of concern as very limited in most rural communities in the Vhembe district which serious lacks active

engagement and campaign on these issues (Mshweshwe, 2018). Similarly, national awareness initiatives have failed to bear the required fruits as they exclude most of the affected rural community members due to poor diffusion of information to the victims in communities when using different communications such as print media, radios and televisions (Gottert, Pulerwitz, Haberland, Mathebula, Rebombo & Spielman, 2020). According to Gottert et al, (2020) most rural communities still face challenges in accessing electronic media due to several issues and are out of touch with some changes in laws or where to get help and the type of help to deal with IPV issues. Because of a lack of accurate information, IPV victims and those who may want to assist in the rural communities are unable to challenge the abuse in the ways their counterparts do in urban spaces (Gottert et al, 2020; Mshweshwe, 2018). Therefore, a good number of women are still not aware of the domestic violence Act and its provisions thereof. This lack of knowledge about support services available and the rights of IPV victims and survivors deprives most women in rural communities of the ability to make correct decisions as well as use appropriate resources to free themselves from abusive marriages (Rasool, 2015). Furthermore, the lack of knowledge about domestic violence is a major challenge that prevents women in a rural community from identifying abusive situations as it is taken as the norm that men should always dominate other female family members as well as their wives and those they in relationship with (Gottert et al, 2020; Mshweshwe, 2018). Cultural beliefs and social norms which emphasise marriage and relationships, cause women to reconsider their situation and subsequently choose to remain in abusive situations to protect their ego and the name of their families (Rasool, 2015). In light of these findings, a need to develop a strategy to empower women against IPV occurrences is imperative.

From the above discussions, it is apparent that IPV is due to a complex combination of situational, religious, personal, socio-economic and cultural factors which conspire to cause unintended violence among people in a relationship (Gottert et al., 2020). Therefore, researchers in the health as well as in the social sciences use the ecological model that explains the inter-relatedness of different factors which contribute to violence within an intimate relationship. This framework is based on known risk factors starting from relationships, individual, family, community and societal levels (Shanaaz, 2010; Heise & Garcia Moreno 2002). Factors that are included at the personal or individual level are among others, having witnessed violence between married couples in a family, and having experienced abuse as a child, (Shanaaz, 2010; Bandura, 1977; Gelles & Straus, 1979). Some researchers cite alcohol abuse, an absent or rejecting father and a personality disorder as critical factors (Shanaaz, 2010; Heise & García-Moreno 2002; Heise 1998). Literature shows

existing factors at the micro level such as relationships between intimate partners or their families, the conflict between married couples; the domination of men in traditional families; and men controlling family financial resources, all of which have a potential to result in violent behaviour when women attempt to refuse to be subdued (Heise & García-Moreno 2002; Heise 1998; Basile et al., 2013). Most of these factors are well-documented in feminist studies (Dobash & Dobash 1979). At the community level are operational factors such as community attitudes to IPV; low socioeconomic status or unemployment; women's isolation and lack of social support (Shanaaz, 2010). In traditional communities or societies, there are rigid gender roles that inherently entitle male individuals to privileges promoting ideas and beliefs of women being owned by husbands; cultural beliefs promoting tolerance of IPV as a way strong masculinity and male dominance over women (Shanaaz, 2010; Heise & García-Moreno 2002; Heise 1998). This is illustrated in Figure 1.1.

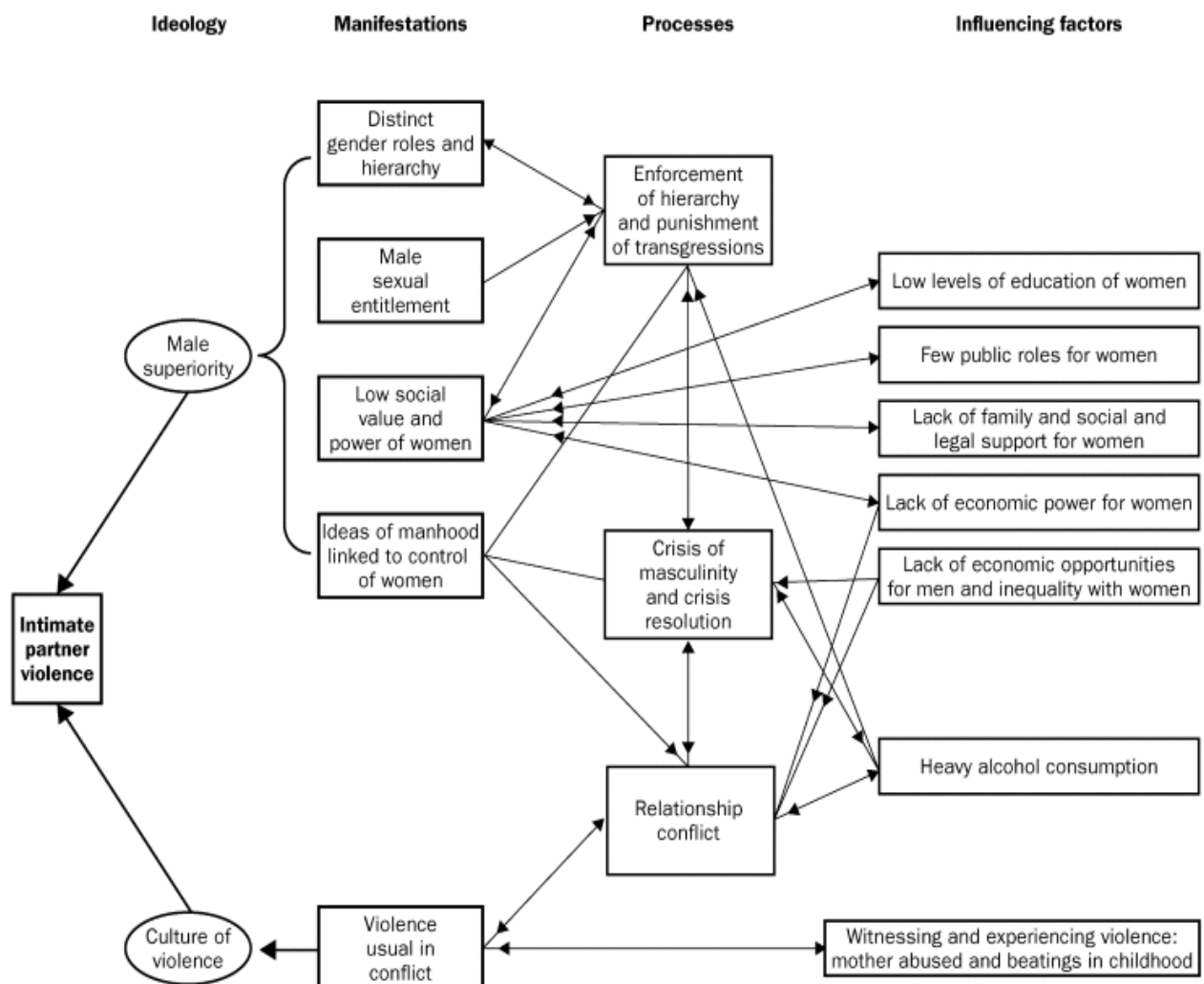


Figure 1.1: Causes of intimate partner violence.

Source: Jewkes, 2002

IPV has severe consequences for women in relationships and psychological as well as physical and health consequences. Intimidation and humiliation are some of the psychological consequences women suffer at the hands of men in society. The consequences of intimate partner violence are very profound. A growing body of evidence documents the psychological, physical, behavioural and emotional negative effects of IPV on the well-being and health of women (Centre for the Study on Violence and Reconciliation, 2016). The physical effects of gender-based violence include being infected with HIV (women in abusive relationships hardly negotiate for safe sex fearing violence) (Dillon, Hussain, Loxton, Rahman, 2013), eyesight impairment (being hit by a fist in the eyes or face), backaches (a result of a severe beating, kicking on the back), cardiovascular problems (due to being hit with rigid objects or punched with fists), head injuries (repeatedly punched or stabbed), hearing impairment (head butting, punching of ears), internal bleeding (damage of organs due to repeated punching, kicking, hitting with fists) (Kate, 2018), unwanted pregnancies (resulting from fear of openly talking about engaging family planning), miscarriages (due to distress, kicking, biting with fists during pregnancy) (American Psychiatric Association, 2015; Krug, Dahlberg, Mercy, Zwi, & Lozano, 2015)

The psychological effects of GBV include serious depression whose symptoms are tiredness, outbursts due to uncontrollable rage, insignificance, powerlessness, bleakness and irritability, insomnia, restlessness, loss of appetite or overeating (Kate, 2018). The author further cites other effects of GBV such as trauma which manifests as anger, self-mutilation, continuous sensations of meaninglessness, sorrow and being obsessed with the offender (Kate, 2018). Some studies identify the effects of GBV as generalised anxiety disorders in which the victim feels overanxious, fearful as well as constantly worried (Dillon, Hussain, Loxton, Rahman, 2013). Similarly, GBV effects such as posttraumatic stress disorder which includes hypervigilance, hyperarousal, intrusive memories, nightmares, numbing and flashbacks have been extensively researched (American Psychiatric Association 2013; Sadock et al. 2015). The behavioural effects of GBV cause victims to live in fear as a result of the violent nature of the relationship; seclusion is a way of avoiding the controlling behaviour of the abuser, who deliberately isolates the victim from family members, friends and colleagues as a way of the cover-up of misdeeds (Dillon, 2013; Kate, 2018). Victims of GBV have been reported to abuse alcohol so that to emotionless and ignore the distressing memories of GBV (Kate, 2018). Some studies report a lack of confidence due to being regarded as not of use; low self-esteem resulting from being despised and insulted as being useless and stupid every time (American Psychiatric Association 2015; Sadock et al. 2015). Extreme situations involve suicidal ideations as a way of escaping from the abuse; covering up by lying or excuses for the violent

behaviour of the abuser (American Psychiatric Association 2015; Sadock et al. 2015; Kate, 2018).

In response to the IPV plight, South Africa has made strides in uplifting women in the country. The S African government has committed and signed various international and regional conventions to protect the rights of girls and women and passed various acts and laws such as the 2012 Criminal Law, the 1998 Domestic Violence Act (Sexual Offences and Related Matters) Amendment Act, the 1998 Maintenance Act and the 2011 Protection from the Harassment Act. The Domestic Violence Act No 116 of 1998 was effected/passed and implemented to provide for the issuing of a protection order concerning DV and for the matters connected therewith. The Domestic Violence Act No 116 of 1998 was implemented to decrease abuse within families and to ensure that women are treated fairly by their male partners inside their homes. The act protects all women involved in any kind of relationship (Domestic Violence Act, 1998). There are suggestions that South Africa's constitution is among the most progressive ones in the world because of its ability to guarantee gender equality (Molebeleli, 2018). The constitution of the RSA has a provision for the protection of women against any form of abuse (Department of Social Development, 2014).

The Victim Empowerment Policy (VEP) of 1998 was introduced and its purpose was to facilitate the effective implementation of the Domestic Violence Act, of 1998 and help to address the psychological and physical needs of intimate partner violence survivors (VEP,1998). Accordingly, to address the psychological, as well as the physical needs of survivors, counselling services, shelters, and victim empowerment, were established (Mshweshwe, 2018). However, many women bypass these services seeking support from family and friends. Most efforts to address IPV in SA have focused on providing health and legal responses to IPV survivors making them ineffective in addressing the major causes of violence to prevent and/or stop IPV before it occurs (Department of Social Development, 2014). 'Crisis management' or 'symptomatic intervention' of IPV which is usually used is ineffective due to a shortage of the appropriate human, technical and financial resources needed to sustain the full application of laws and policies as well as monitoring their implementation. It is important to acknowledge the deficiencies of intervention strategies as well as the existing barrier to effectively addressing IPV. There arises a need for inclusivity which recognises critical stakeholders who can bring in new ideas that can facilitate a move away from responsive solutions to preventative approaches that address the root causes of IPV in a harmonised and holistic manner. Such holistic approaches must be hinged on

intervention strategies that must range from protection and prevention to response, support and long-term care (Department of Social Development, 2014).

1.3 Statement of the Problem

Despite all the efforts made by the global community, South African communities continue to suffer and experience high rates of IPV, especially in rural areas. To date, violence against women in South Africa is regarded as a national emergency. Although the national picture reflects a decrease of 69.4% from 9 990 cases between 29 March 2019 and 22 April 2019 to 3,061 since the lockdown until 20 April 2020, with the difference of 6,929, these statistics are still worryingly high because one death is too many. In the Vhembe district, about 198 women and 345 women reported cases of IPV and sexual assault in January and February 2018 respectively. Based on the researcher's personal experience during her tenure at the district council in the Vhembe district and legislature in the Limpopo Province, at least 40 women reported sexual assault monthly, and between 100 to 120 women experienced intimate partner violence per month.

Table 1.1: Cumulative IPV and TTC clients reached

	January-18	February-18	Total
IPV clients	198	345	543
Number tested	137	279	416
Tested negative	130	276	406
Tested positive	7	3	10
Sexual assaults clients	48	37	85
Tested negative	29	29	58
Tested positive	5	2	7
Known positive	3	0	3

Source: Thohoyandou Victim Empowerment Centre 2019

Despite all the efforts made by the international community and South African communities in dealing with issues related to IPV and the prevention thereof, the reports still show a high number of cases of IPV as tabulated in Table 1.1. In 2015/2016, 437 women reported IPV

whilst 314 women reported sexual assault cases in Limpopo (Thohoyandou Victim Empowerment Centre, 2019). In January 2018, about 198 women were seen whereas 345 women reported IPV in February 2018. This is high when compared to 2015/2016 statistics. There is strong evidence that IPV exists in a vicious cycle of mental illness, poor reproductive health, HIV, poor childhood development and chronic disease, and leads to numerous injuries, disability and death (Joyner et al., 2015). Therefore this study attempts to develop strategies to empower women against IPV occurrences in the context of the Vhembe District.

1.4 Rationale for the study

IPV and domestic violence are well-documented in several studies conducted globally. For instance, in 2010, Madzimbale studied the experiences of physical violence by women living with intimate partners. In 2014, Davhana - Maselese conducted a study on the comparison of trauma on survivors of sexual assault and IPV in Limpopo. So far, there are scarce studies that developed strategies to empower women against IPV occurrences in Limpopo province, South Africa. Therefore, the researcher saw a need to conduct a study on the empowerment of women against IPV so that a strategy may be developed, which will assist in the reduction of IPV because addressing IPV needs a shared responsibility in which public health plays an important role. An all-inclusive public approach to IPV must comprise strategies to prevent IPV from happening in the first place, but it should take into account appropriate action to identify those at risk, and provide appropriate support and assistance to IPV victims to alleviate its impact on their health and prevent possible impending harm (McKeown and Harvey, 2018). This problem can be very costly because women in abusive relationships may increase demand for the use of existing health facilities and other available services (Joyner et al., 2015).

1.5 Significance of the study

It is hoped that the proposed strategy may assist the department of social development, justice and health to strengthen health systems to respond to IPV. The strategy may also assist victim empowerment centres, trauma centres and non-governmental organizations working with victims of IPV to develop campaigns that aim to empower victims of IPV. The research findings may also contribute to the body of knowledge in understanding the issues around IPV, especially within the rural context and develop a strategy on how to solve the problem. The insights gained from this study may assist victims of IPV to prevent or cope with gender-based violence. The findings of the study may assist other researchers in further addressing IPV as a health threat and assist to find innovative solutions to reduce IPV in S Africa.

1.6 General objective of the study

The study aims to develop strategies to empower women against IPV occurrences in the Vhembe district.

1.7 Specific objectives of the study

To achieve the purpose of the study, the researcher formulated the following specific objectives in two phases:

Phases:1a Quantitative study

- To measure the level of general knowledge regarding intimate partner violence among IPV victims in the Vhembe district.
- To describe the victim's motivational attitude towards the acquired IPV information to act against any form of IPV behaviour in the Vhembe district.
- To assess the behavioural skills used by victims in dealing with any IPV occurrence.

Phase: 1b Qualitative study

The qualitative strand was dependent on the findings from the quantitative strand because the study followed an explanatory sequential mixed methods design.

Phase 2: Strategy development

To develop the strategies to empower women against IPV occurrences in the Vhembe district.

1.8 Research questions

What are strategies that can be used to empower women against IPV occurrences in Vhembe District?

1.9 Definitions of concepts

1.9.1 Empowerment

Empowerment is an interactive process that provides the resources, tools and environment to develop and build, and increases the effectiveness and ability of others to set and reach goals

for individual and social ends (Wittmann-Price, 2004). Empowerment in this study means power within (internal qualities such as self-confidence or critical thinking skills that enable IPV victims in dealing with any form of violence) and power which is the ability to make independent decisions without fear of being dominated.

1.9.2 Intimate Partner violence

IPV is 'behaviour within an intimate relationship that causes psychological, physical or sexual harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours (Dillon, 2013; WHO, 2016). In this study, IPV refers to any behaviour within an intimate relationship that causes psychological, physical or sexual harm to women who are in an intimate relationship.

1.9.3 Strategies

A strategy is referred to a set of plans or general plans intended to achieve something, especially over a long period (Lew, 2013). In this study, strategies refer to measures meant to prevent future occurrences of IPV among women victims.

1.9.4 Knowledge

Knowledge has been defined as the ability to understand oneself and to make a person aware of how knowledge affects situations and influences everything one does (Fisher & Fisher, 2006). For this study, personal knowledge implies personal knowledge of IPV victims about making emancipated decisions in the prevention of future occurrences of IPV.

1.9.5 Motivational attitude

Motivational attitudes are both negative and positive attitudes held by a person toward health-promoting behaviours (Fisher & Fisher, 2006). This study encompasses personal attitudes and willingness to use or not to use acquired IPV information in preventing future occurrences of IPV.

1.9.6 Behaviour

Behavioural skills have been reported to be very important in studying IPV because they are indicative of the actual abilities and effectiveness of a person in executing certain skills (Fisher

&Fisher 2006; MacKenzie, 2016). In this study, self-confidence, independent decision making or critical thinking

1.9.7 Factors

Factor refers to the influence, fact or circumstance that contributes to a result (Lew, 2013). In this study, personal, socio-cultural, religious as well as psychological factors are complex factors that contribute to IPV among women.

1.10 Theoretical Framework

The study was guided by the Information Motivation Behavioural model (IMB), which is the intervention-oriented framework which combines aspects of social cognitive theory (Mittal, Thevenet-Morrison & Landau, 2017) and other widely used health behaviour models (Fisher & Fisher, 2006) to reduce health-related risk behaviours. The IMB model of behavioural change was developed in 1992 by Fisher and Fisher to explain and modify HIV risk-taking behaviours (Fisher & Fisher, 1992). The IMB emphasises that the information related to health motivation, and behavioural skills are the critical determinants of whether healthy behaviour is performed (**See Figure 1.2**). To adopt the prevention behaviour, people must have information which will translate easily into action, motivation to act, and skills to perform the behaviour. If a person is well-informed, motivated to act, and has the necessary skills and confidence to act, he/she is more likely to initiate and maintain the health-promoting behaviours which produce positive outcomes. Therefore, according to IMB, health interventions/strategies should be focused on: a) Dispersing effective health information which is relevant to the target health behaviour and specific to the population. b) Increasing personal motivation and social support and c) Skill-training to increase self-efficacy for performing healthy behaviour.

In this study, the IMB model is relevant as it focuses on issues of women empowerment in behavioural change. The notion of empowering individuals is discussed by Campbell (2003) who identifies three dimensions to it: provision of the information to assist individuals' rational health choices; motivation to perform healthy behaviours, as well as training them in appropriate behavioural skills. The IMB model has been used as a framework in the conceptualisation of the gap between having knowledge or information about a problem, and knowing what to do, and doing it (Crooks, Goodall, Baker & Hughes, 2006). In the case of IPV violence prevention, these models would suggest that IPV victims need accurate information about the problem of intimate partner violence against women and the role women could play

in preventing this violence. Women also require motivation to attempt behavioural change and behavioural skills that are necessary to undertake this process (Crooks, et al., 2006).

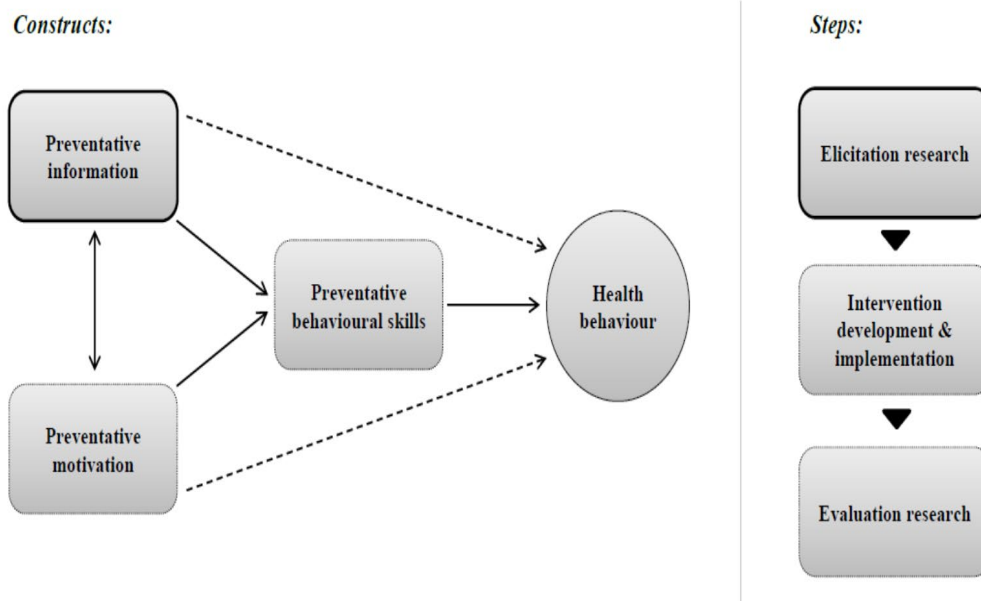


Figure 1.2: Information Motivation Behavioural Skills Model,

Source: Fisher et al., 2006

Research shows that accurate information about the problem faced by women in abusive relationships is important in supporting victims' transitions to healthy behaviour choices (Crooks, et al., 2006). Women and men need more accurate information about the challenges of abusing women, and about the day-to-day relationship challenges faced by their children. Accurate information on its own is not a sufficient condition for persuading women and men in counteracting IPV, but motivation and behavioural skills are needed for the mothers and fathers to intervene when their children engage in violent behaviour (Crooks, Goodall, Baker, & Hughes, 2006). Behavioural skills and motivation are the most critical determinants and these two are independent of behaviour change. When behavioural skills are familiar or uncomplicated, motivation and information can have direct effects on behaviour (WHO, 2018). The model has been proven to be effective and the application of its constructs has accounted for an average of 33% of the variance in behaviour change (WHO, 2018). The health-promoting behaviours being focused on by this were those that sort to empower women so that they will be able to resolve issues that lead to IPV thereby reducing occurrences of IPV within their homes.

1.10.1 Information-Motivation-Behavioural Skills model IMB Constructs

- **Information**

The need for accurate information about the problem as an essential building block in supporting individuals' transitions to healthy behaviour choices cannot be overemphasised (Crooks, et al., 2006; Fisher & Fisher 2006). Captured within preventative information are facts about enacting a specific behaviour, heuristics regarding the behaviour, and implicit theories held about the behaviour (Fisher & Fisher 2006). In this context, information about basic knowledge about IPV which is outlined in the Domestic Violence Act, South African Constitution and Chapter two of the Constitution (Bill of Rights) will be assessed using a questionnaire on a representative sample.

- **Motivation**

The 2nd construct within this model is preventative motivation, which incorporates personal motivation as well as social motivation. *Personal motivation* refers to attitudes, both negative and positive, the person holds toward partaking in health-promoting behaviours. This study encompasses personal attitudes towards avoiding IPV occurrences in the home, the perceived social support for such behaviour and woman's perception or subjective norm of how other women who are IPV victims behave.

- **Behaviour skills**

The IMB model stipulates that a highly informed and highly motivated person requires appropriate behavioural skills to properly engage in health-promoting behaviours. These behavioural skills include a person's actual capability as well as self-efficacy with performing the skills. In this study, behavioural skills include ensuring that the woman has specific behavioural tools or strategies necessary to prevent IPV such as self-regulating strategies and enlisting social support. These include (a) *placating*: attempts to change the perpetrator's or abuser's behaviour without challenging him (Riddell, Ford-Gilboe, & Leipert, 2008); (b) *resistance*: efforts which directly challenge the abuser's behaviour (Goodman et al., 2003; Riddell, Ford-Gilboe, & Leipert, 2008); (c) *planning safety*: these are strategies needed to enhance woman's resources or alternatives to evade or defend herself; (d) *legal*: the ability of women to seek assistance from legal system for protection against IPV perpetrators; (e) *formal network*: Enable women to access other resources outside than the legal assistance, these include health or religious services; and (f) *informal network*: aimed at making women be able to ask for advice or support from the family members or friends or existing structures in the

local community thereby increasing alternative resources at the disposal of IPV victims (Riddell, Ford-Gilboe, & Leipert, 2008).

1.10.2 Application of the model to this study

The IMB model is an elicitation-intervention-evaluation approach with three stages found useful in inspiring the utilisation of preventive and precautionary health behaviour among families, communities and societies (Singh, 2010; Fisher et al., 2009). In this study the IMB model will inform the formulation of objectives, development of data collection instrument, guiding the literature review, guiding data collection, analysis, organizing the presentation of findings and development of the strategy. This is illustrated below in the steps.

Step 1: Elicitation research

When using the IBM model, the first thing done by the researcher is to conduct '*elicitation research*', using a demonstrative sample of the target population to which the problem being studied applies (Singh, 2010; Fisher et al., 2009). The purpose of the elicitation research stage is to determine the level of health-enabling behaviours and/or health-risk behaviours, together with "preventative information", motivational and behavioural skills, among the target population (Barak & Fisher, 2003; Singh, 2010: 73). Ideally, elicitation research enables the researcher to have insights into the "deficits" and "assets" in the main constructs that contribute to the understanding of the study. In the effort to cover the scope of IPV as much as possible, IBM allows the researcher to gather both quantitative and qualitative data and interpret them as much as possible. Therefore, Phase 1 of this study was designed to be elicitation research with Phase 1a collecting quantitative data and Ib the qualitative data thereby enabling the researcher to have "substantive data needed to identify prevalent preventative information, motivation, and behavioural skills constructs of the IMB model" (Singh, 2010). In this regard, this study collected qualitative and quantitative data as part of elicitation research using questionnaires and interviews.

Step 2: Intervention development and implementation

The intervention development and implementation is a crucial step which follows the elicitation research step. In this step, the researcher developed and implemented the intervention in a practical manner and being population-specific and conceptually focused (Fisher et al., 2009; Singh, 2010). The intervention strategies were to be based on clearly define constructs being

supported by the quality empirical data sourced from the right target population. IBM requires that the development of the intervention be guided by sound findings made in the elicitation research step so that identified asserts with the target population can be used to address the shortfalls or problematic areas to address IPV (Fisher et al., 2009). In this context, the study findings from elicitation research will be used to develop a strategy to empower women against IPV occurrences in the context of the Vhembe district.

Step 3: Evaluation research

According to IBM, there is a need to evaluate the research at some point, and this takes place in the 3rd step of the process. The main use of the *evaluation research stage* was to confirm if the developed intervention was applicable and had an influence on the preventative strategies, “motivation and behavioural skills of individuals and the health promotion behaviour in the targeted population (Singh, 2010; Fisher et al., 2009). In the context of this study, this step involves the development and validation of the proposed strategy by stakeholders.

1.11. Structure of the study

This study is organised in 8 chapters namely: Chapter 1, which introduces the study and proves the background. Chapter 2 is a scoped literature review on IPV interventions in the Limpopo province. The research methodology is presented in Chapter 3. Quantitative results are presented and interpreted in Chapter 4. Chapter 5 presents qualitative results. Chapter 6 discusses findings from both quantitative and qualitative results. Chapter 7 is on the development and the validation of the developed strategies. Ultimately, Chapter 8, presents the conclusions, contributions, limitations and recommendations of the study.

1.12. Summary

This chapter introduced the study by providing the introduction, background to the problem, the statement of the problem, the rationale of the study as well as the significance of the study. It is in this chapter where the researcher outlined the main aim as well as the specific objective of each phase however phase 1b objective was not outlined as it is dependent on the findings of phase 1a results. The research question was stated, and different concepts were defined. The theoretical framework of the study which is the information-motivation-behavioural Skills model was discussed in detail. Its constructs were detailed in the study as they going to guide

the researcher in the last phase which is the development of the strategies and validation. The next chapter presents a detailed literature review.

CHAPTER 2

MAPPING IPV INTERVENTIONS IN LIMPOPO: A SCOPING REVIEW

2.1. Introduction

The purpose of this study was to develop strategies to empower women to cope with IPV in the Vhembe district. To develop IPV strategies, the study critically examines IPV prevalence and the major contributing factors in the Limpopo province, focusing on the Vhembe district. Furthermore, a critical analysis of IPV intervention strategies and their perceived effectiveness to prevent IPV in the district is provided. Therefore, this chapter presents a detailed literature review on IPV, its causes, intervention strategies used and their effectiveness in the Vhembe district.

The literature review answers these two questions:

1. What are the available Intimate Partner Violence interventions in Limpopo province of South Africa?
2. What is the perceived effectiveness of such interventions to prevent IPV occurrences?

Furthermore, the chapter presents the theoretical framework that guides this study. The remainder of the chapter is organised in literature review subsections.

2.2. Intimate partner violence

There is a plethora of literature which proves that intimate partner violence (IPV) against women is a social and public health problem widely spread across the world (Bonnes, 2016). WHO (2016: 13) posits that IPV takes place in an “intimate relationship where both the perpetrator (man) and the victim (women) know each other and have either been or are still in an intimate relationship of some sort”. Several literature sources describe IPV against women as any act of physical and sexual aggression or harm, sexual coercion, controlling behaviours, or psychological/emotional abuse within an intimate relationship by a current or former partner/spouse (Mthembu, Mabaso, Reis, Zuma & Zungu, 2021; 2011; World Health Organization, 2017). Furthermore, the literature emphasises that IPV against women is historical, threatens the lives of women, and violates women’s human rights in an existing or past intimate relationship (Sere, Roman & Ruiter, 2021). This arises from the fact that IPV against women entails coercive behaviours solely intended to control one’s intimate partner using several forms of abuse such as physical, threats of physical abuse, psychological abuse,

sexual violence, continuous social isolation, deprivation, intimidation and/or economic subjugation (Danis & Bhandari, 2010; Milani, Leschied & Rodger, 2018). According to Aizpurua, Copp, Ricarte and Vázquez (2017), IPV behaviours by intimate partners are intended to constrain women's social mobility, ability to work, or access to friends and relatives. This implies that IPV remains one of the most prevalent means used by men to systematically commit violence and abuse against vulnerable women (Cork, White, Noel & Bergin, 2018). IPV has become a means by which men deliberately violate the human rights of women globally (Devries, Mak, García-Moreno, Petzold, Child, Falder, 2013; Ekhatobayode, Hanmer, Rubiano-Matulevich & Arango, 2022.). Several authors on IPV against women present evidence of the high prevalence of this pandemic globally and nationally (Mthembu et al., 2021; Mpondo, Ruiters, Reddy & van den Borne, 2016; Garcia-Moreno, 2005; Joyner, Rees & Honikman, 2015; Bott, Guedes, Goodwin & Mendoza, 2012). Due to mounting calls on the need to alleviate IPV against women, more studies are still being conducted in this area. The coexistence of different types of IPV against women has been documented in several studies. Physical IPV is usually accompanied by sexual IPV, which in turn is frequently followed by emotional abuse (Ahinkorah, Dickson & Seidu, 2018; Do, Weiss & Pollack, 2013).

2.3. Prevalence of intimate partner violence globally and regionally

The vulnerability of women to “assaults, sexual violence and homicide by intimate partners and unknown perpetrators communities and families” (Frade & De Wet-Billings, 2019: 5). IPV is described as a globally health pandemic because nearly one in every three women is subjected to forms of abuse such as physical, sexual violence or emotional by intimate partners at some point during their lifetime (World Health Organization, 2021; Kyegombe, Stern & Buller, 2022). Past and current literature shows a growing concern about IPV against women that takes place in all countries around the world, though at variable scales of prevalence (WHO, 2016). According to WHO (2013), the global prevalence of physical and/or sexual IPV among intimated partnered women was 30.0% in 2013. The report further shows that countries in Africa, East Mediterranean and South-East Asia Regions had the most IPV prevalence cases close to 37% of which physical or sexual abuses were noticeably high (WHO, 2013; Do, Weiss & Pollack, 2013). The Americas region recorded the second highest prevalence of nearly 30% of women having experienced IPV at least once in their intimate relationship (Do, Weiss & Pollack, 2013). Literature shows that a lower IPV prevalence of 23% was experienced in the high-income regions such as the European and the Western Pacific regions, (WHO, 2013). These results show that IPV against women exists in all countries across the world regardless improved economic and educational status of the countries. This is confirmed by a study by Bloom and Tavrow (2018) which report that women from all

socioeconomic levels, ages, occupations, religions, and ethnicities across every country in the world are abused by intimate partners. For example, Briggs (2018) reports that a quarter of Australian women in an intimate relationship have experienced emotional abuse from a current or previous partner while one in six women has been physically abused. Findings of a comparative analysis of DHS data from 12 Latin American and Caribbean countries confirm a coexistence between physical and emotional abuse among most (61–93%) of women who experienced IPV within 12 months (WHO, 2016).

Statistics on violence from sub-Saharan Africa studies show a precarious situation of IPV with an overall prevalence of 36%, which is way above the global average of 30% (Conroy, 2014). There is a common cause to worry about the high statistics for IPV against women in Africa that have driven the research to seek solutions to this pandemic (Bones, 2016). Of the 71% of IPV against women in sub-Saharan Africa, 36% of the severe abuses have been recorded from Southern Africa (Bones, 2016, Mthembu et al., 2021). A study conducted in Malawi by Bazargan-Hejazi, Medeiros, Mohammadi, Lin and Dalal (2013) reports that between 11% and 30% of women were victims of physical IPV. Similarly, high IPV prevalence is reported in countries such as Botswana, 50% (Bloom & Tavrow, 2018), Tanzania, 35.8% (Mulawa, Kajula, Yamanis, Balvanz, Kilonzo & Maman, 2016), Zimbabwe, 34% (Chireshe E. 2015; Muchemwa & Odimegwu, 2021), Namibia, 33% (Bikinesi, Mash, & Joyner, 2017). South Africa is ranked among the top countries with IPV against women with prevalence ranging between 35% and 52% (Frade & De Wet-Billings, 2019; Mthembu, et al., 2021). Research shows women experience different forms of IPV such as severe physical abuse such as beating and shoving, sexual abuse such as forced sexual intercourse, and emotional abuse leading to stress and possible suicide among women of different ages (Bikinesi, Mash, & Joyner, 2017; Spencer, Haffejee, Candy, & Kaseke, 2016). Studies further show that IPV against women is more prevalent in less economically developed areas than in those areas with improved socio-economically viable (Russell, Cupp, Jewkes, Gevers, Mathews, LeFleur-Bellerose & Small, 2014).

2.4. Prevalence of intimate partner violence in South Africa

There seems to be a consensus among several authors that IPV in South Africa has reached a critical level of being public health epidemic that needs serious attention (Gordon, 2016; Russell, et al., 2014). According to Russell et al. (2016), IPV in South Africa has permeated all societies despite putting in place strong legal and social structures to address the violence. The Committee on the Elimination of Discrimination against Women (CEDAW) (2021) a

watchdog of the United Nations Human Rights Commission posits that IPV and other forms of violence against women in South Africa have reached an alarming proportion despite the presence of a strong justice and legal system which fails to prosecute the perpetrators of the violence. This is evident that no South African woman is immune to IPV. Joyner, Rees and Honikman (2015) posit that half of the women murdered in South Africa are killed by their intimate partners while the IPV survivors are always reluctant to disclose their problems due to fear of being stigmatised.

An analysis by Stats South Africa (2020) on gender-based violence reveals that IPV against women has been the most prevalent perpetrated by South African men in recent years. According to Odeku (2021), IPV a form of gender-based violence surged steeply during the COVID-19 pandemic when women were forced by government lockdowns and restrictions to stay at home with abusive partners. Literature shows that one in five adult women experienced physical violence despite progressive reforms in the constitution, legal system, and the implementation of victim empowerment programmes (South Africa Demographic and Health Survey, 2016). Stats SA (2020) reports that IPV is greater against African women than other races, most (40%) prevalent among divorced/separated women compared to other marital statuses and mostly driven by poverty. Stats SA (2020) indicates that IPV of various forms remains more prevalent among less-educated women who were unemployed. There is a cause of concern in South Africa among other countries with an IPV prevalence of 50% in which women continue to experience IPV (Gordon, 2016; Sere, Roman & Ruiter, 2021). The South African Police Services (SAPS) confirms a 7.7% rise in femicide, with a sudden increase of women murders from 9.6% to 20.8% between 2015 and 2017 (SAPS,2019). In a snapshot of the IPV by South African provinces, sexual and physical violence are reported to be highest in North-West and Mpumalanga with close to 30% of women who reported violence, while the Limpopo and KwaZulu-Natal provinces account for less than 20% of the same IPV (Stats SA, 2020). However, the stats could not be conclusive since most of the victims are always hesitant to report violence to the police or other structures put in place for that purpose (Baloyi, 2017; Mthembu et al., 2021). Despite the seemingly low IPV reported for Limpopo, the situation on the ground in Vhembe districts shows the contrary picture which warrants an investigation with aim of developing an intervention strategy to address the violence against women by their intimate partners.

2.5. Prevalence of inter-partner violence in Vhembe District

There is substantial literature alluding to the high prevalence of IPV against women in the Vhembe District. A study by Pengpid & Peltzer (2014) identifies Vhembe Districts as having the highest prevalence of domestic violence in the Limpopo province. The same study on 268 women aged at least 18 years from Vhembe District who had been granted a protection order repeatedly found that: 93.7% were physical abuse; 40.7% were sexually assaulted at least once by their intimate partners within 3 months; 58.2% were stalked by the intimate partners; 94% were emotionally abused and 99.3% reported to be under threats from intimate partners. Analytical data from the provincial justice department affirm that the Vhembe district has the highest prevalence of domestic violence in the Limpopo province with approximately 12000 cases annually (Department of Justice, 2020). A report from a community-based watch group Thohoyandou Victim Empowerment Programme (TVEP) shows an average monthly increase of 120 cases of domestic violence in the district (Thohoyandou Victim Empowerment Centre, 2019). The commonly reported IPV cases were physical, sexual, verbal and emotional physically abuse by intimate partners. The South African Broadcasting (SABC) News (2019) reports that the Minister of Justice Lamola was shocked by the high level of domestic violence in the Vhembe district. The same news bulleting indicated that courts in Vhembe were failing to cope with staggering rates of gender-based violence committed in the district (SABC News, 2019: 13 September).

The high IPV prevalence in the Vhembe district places the human rights of women and girls children under threat as they are forced to live with the realities of various forms of violence and perpetual marginalisation and abuse by men (Pengpid & Peltzer, 2014; Thobejane, Mogorosi & Okere, 2017). Vhembe district is mainly rural, where support for IPV victims may hardly be found within the proximities of the villages without women having to rely on men who in turn take advantage of these deficiencies (Tshifhumulo, Thobejane & Chimeri, 2018). Moreover, the way of life in the district, mainly traditional, makes it difficult to emancipate themselves from violent relationships. Tshifhumulo, Thobejane and Chimeri (2018) stress that women living in rural villages tended to be prone to isolation due to the long distance to be travelled to get support from family and friends and to access formal police and domestic violence support services. There are limited medical and counselling services in the rural Vhembe district, and this makes it difficult for IPV victims to access needed assistance after abuse. The prospects of dealing effectively with IPV in the Vhembe district are compounded by the fact that offenders and/or victims might be well-known people in the villages or even in regional communities (Thobejane, 2019). With these alarming IPV cases in the district, it is

important to understand the causes and effects so that informed decisions could be made on the possible homegrown solution.

2.6. Factors contributing to intimate partner violence in Vhembe

Several causes of IPV against women have been documented in the existing literature. Most of the causes of IPV are complex and a combination of personal, situational, religious and socio-cultural factors that connive to trigger violence (Ahmed, Changole & Wangamati, 2012; Gordon, 2016; Kyegombe, Stern & Buller, 2022). Several models and theories such as systems theory, ecological theory, exchange/social control theory, resource theory, and the subculture-of-violence theory (Lawson, 2012), and set of hypotheses (dependence, submission, compensation and transgression hypotheses) (Bones 2016), Information Motivation Behavioural model, (Fisher and Fisher 2006), have been used to explain the causes of IPV against women.

The *Systems theory approach* views a family as a system made of interacting individuals with different interests and such, the conflict due to misunderstanding within the family system is considered normal and inevitable, but it is how the family system manages the conflict which is important to understand why the systems use violence to resolve the conflict (Lawson, 2012; Giles-Sims, 1983). The systems theory approach is important in examining the effects of feedback and response on the escalation of a conflict into violence or on the ability of the partners involved in maintaining nonviolent behaviour (DeKeseredy & Dragiewicz, 2007; Lawson, 2012). A researcher who applies the systems theory can have an insight into how the characteristics of the family system and the existence and interactions of the individuals result in IPV against women. Several characteristics of family structure such as socialisation, time family members spend together, and stress level need to be investigated to understand their impact on the potential of violence occurring in the system (Giles-Sims, 1983). The challenge of using the system theory approach in this study was constrained by the time factor which the researcher needed in observing the families during the COVID-19 pandemic.

The *exchange/social control theory* regards family violence result of rewards for violent behaviour perpetuated by some family members (Lawson, 2012). According to Gelles (1983) and Lawson (2012), some of the proponents of this theory:

- family violence is prevalent when there are more gains derived from it by the perpetrators and nothing happens to the perpetrators;

- family violence is more likely to take place if the family does not have proper and effective social controls to reduce the negative effects of the violence (Lawson, 2012); and
- family and social structures, inequality (gender, status, economic resources, or physical strength), privacy norms of the family, and perceptions of masculinity reduce the costs and thereby increase the rewards of using violence.

It is believed that violence tends to be used in a relationship where there are no reciprocal benefits between the two partners, especially by that one who thinks is not benefiting.

The *resource theory* was widely used by Goode (1971) and Allen and Straus (1979) to understand family violence. The resource theory posits that violence is due to individuals who misuse their financial resources, educational and social skills, status and respect to attain goals that promote violence (Goode, 1971; Lawson, 2012). Because of this, violence becomes a form of resource such individuals use against those perceived as weak or not liked, to achieve personal interests, especially in the absence of other resources (Goode, 1971; Allen & Straus, 1979). According to the resource theory, the tendency of IPV against women occurring increases in families with depleted resource use (Anderson, 1997; Costello & Laub, 2020). The resource theory has been used in studies which investigated the effect of socio-economic factors such as poverty and lack of financial conflicts and the use of violence to solve them (Lawson, 2014; Bones, 2016). Studies which applied the resource theory found that male violence "against an intimate partner was utilised as the last resource to gain power and control when the male partner noticed a lack of or a disparity in key resources such as income, educational status, work-related prestige of the woman (Basile, Hall & Walters, 2013). Social resource limitations, and social stress, together with the dominant sex-role expectations tend to increase the violent behaviour of the male partners whose intimate partners have better resources and social status (Gelles, 2007; Basile, Hall & Walters, 2013). This implies that male partners with poor financial status, low educational level and poor standing in the community compared to their female partners are likely to use violence to gain power and control over their women (Basile, Hall & Walters, 2013; Lawson, 2014). Basically, in the absence of material and cultural sources of power and control, men use IPV to subjugate their female partners (Gelles, 2007; Basile & Hall, 2010). Similarly, unemployed men in rural areas in the Vhembe district might be facing similar resource challenges that would make them prone to IPV tactics as a way of dealing with mounting stress and conflicts in their families.

The *subculture-of-violence theory* by Wolfgang and Ferracuti (1967) regards IPV as a socially learned behaviour usually spread through social customs and values of particular subcultures and has a tendency of making members of certain groups to be inclined to use violence (Lawson, 2012; Mcgloin, Schreck, Stewart & Ousey, 2011). The fact that violence occurs most frequently among a specific subset of the larger community makes researchers believe that it is a value system at work in that subculture that promotes the acts of violence (Lawson, 2012; Ferracuti & Wolfgang, 2002.). According to the subculture-of-violence theory, an individual who is prone to violence must be identified by his adherence to violent norms and beliefs and not simply those who sporadically engage in violence as part of a versatile offending profile (Lawson, 2012; Mcgloin, Schreck, Stewart & Ousey, 2011). According to the subculture-of-violence theory, an individual who is inclined to violence can be identified with his tendency to adhere to violent norms and beliefs but not just sporadic engagement in violence (Lawson, 2012; Mcgloin, Schreck, Stewart & Ousey, 2011). This theory has been successfully used in studies on IPV but was found not effective in analysing violence related to family influence (Lawson, 2012).

A set of four hypotheses have been used to explain and investigate the causes of IPV in some limited studies namely, dependence, submission, compensation and transgression hypotheses (Bones 2016). Each of these hypotheses is briefly explored.

The *dependence hypothesis* postulates that an economically dependent are more likely to face IPV because of the unjust decisions made on her behalf by the husband because of having income and other resources (Hoque, & Makinoda, 2011; Young & Li, 2010). The authors argue that poorly educated women without income have less chance of leaving abusive husbands because they have no means to survive or support their children. Studies have also proved that women with a high economic status than their intimate partners were likely to suffer more IPV violence as they were not able to be submissive. However, such women were free to leave abusive partners to start a new life (Ackerson & Subramanian, 2008; Lawoko et al., 2007; Young & Li, 2010). The *submission hypothesis* According to the submission hypothesis IPV is more likely to be higher in women who are submissive to their husbands, which is an expectation in many traditional African societies that women should be submissive to men (Choi & Ting, 2008). The *compensation hypothesis* claims that men who are unable to fulfil their family duties usually compensate with violence against their female intimate partners (Choi & Ting, 2008; Jewkes., Dunkle, Nduna & Shai, 2010). According to the compensation hypothesis, economically independent women can reject subordination in the

relationship thereby threatening the male partner and leading to increased IPV (Choi & Ting, 2008). The *transgression hypothesis* claims that women who are suspected of going against the norms of society tend to be at higher risk of IPV.

The *ecological theory* was developed by Donald Dutton (2006) applied principles of systems theory to study IPV at the individual personal level (Lawson, 2012). The ecological theory emphasises the individual as the unit of study when addressing IPV, considering the environment and relationships of the individual as important aspects to understand violent behaviour in intimate relationships (Bronfenbrenner, 1979). The strength of the ecological theory is that is developed from existing bodies of knowledge from several disciplines and perspectives that enhance gender-based feminist theories that take into consideration multi-factor theoretical factors beyond the patriarchal set (Heise, 1998; Lawson, 2012). Literature touts the ecological perspective as a holistic and multidimensional model suitable for understanding and intervening to end IPV and its effects. (Prilleltensky & Prilleltensky, 2007; World Health Organization, 2010). The ecological approach integrates different levels needed to act, such as the collective or community, organizational, relational and individual levels. The ecological approach has the advantage of integrating different levels of acting, such as the collective or community, organizational, relational and individual levels (Di Napoli, Procentese, Carnevale, Esposito & Arcidiacono, 2019).

It has been a common practice for researchers to utilise the ecological model in explaining the association of factors that lead to IPV within an intimate relationship (Lawson, 2012). The ecological theory is founded on practically proven risk factors at the individual, relationship, community and societal levels (Di Napoli et al., 2019; Heise & Garcia Moreno 2002). Such factors have been reported in several studies on IPV against women (Gordon, 2016, Lawson.2012, Mthembu et al., 2021; Ahinkorah, Dickson & Seidu, 2018). When studying IPV against women, researchers have been encouraged to look at the community, family and individual factors that may be promoting violence. The community has the potential of contributing to IPV against women by promoting an unfair practice of socio-cultural and religious norms (Danis & Bhandari, 2010). The use of the ecological model allows researchers to understand the community factors that promote IPV. Some community-level factors such as women's seclusion and poor social support; community attitudes approving IPV; poverty or unemployment have been reported as enablers of violent behaviour among perpetrators of IPV (Heise & García-Moreno 2002; Shanaaz, 2010). Lastly, the ecological model views the societal level of entitlement for males as based on the notions of women as being owned by

men as influenced by inflexible gender roles, masculinity which promotes male dominance and cultural norms encouraging the tolerance of IPV (Heise & García-Moreno 2002; Heise 1998). This is illustrated in Figure 1.1. At the relationship or family level, there are factors such as male dominance in the family; marital conflict; and male control over family money (Heise & García-Moreno 2002; Heise 1998 Shanaaz, 2010).

A few studies have been conducted to understand the causes and effects of IPV in the Vhembe District. Jewkes and Morrell (2010) think that the high IPV prevalent in most parts of South Africa can be traced back to the male dominance is a norm and is used to subordinate and control women through any means of violence that men deem appropriate. According to Jewkes and Morrel (2010), to be called a man means oppressing women, particularly intimate partners. A study by Pengpid and Peltzer (2014) with IPV victims in the Vhembe district found that most of the participants lived in fear of their violent intimate partners who always abused them. Similarly, Thobejane, Luthada and Mogorosi (2018) observe that violent men who were socialised to accept gender inequality and gender-based violence were raised to believe that ill-treating women and children were a cultural norm in their communities. Most of the communities in the district have strong traditional, cultural and religious principles that disfranchise women and children by forcing women to be submissive to men (Ahikire, 2014). In such communities, cultural norms are used to justify the abuse of women by men (Thobejane, Mogorosi & Okere, 2017). Submissive women rarely speak about the abuse by their male partners whether married or living together. Culturally, women are discouraged from talking openly about the problems in their marriages as this is treated as a private issue between the intimate partners (Gender Links, 2012). Violent men take advantage of these social structures which promote the use of violence as a tool to abuse women (Ahikire, 2014). The challenge is that rural communities tend to be socially unified and guard against disunity through shared and agreement unwritten values that are promoted against those regarded as intruders or present ideas to disrupt the cultural beliefs (Amadiume, 2015). Unwittingly or through coercion, IPV victims in rural villages tend to accept and share beliefs and values thereby concealing IPV perpetrators (Baloyi, 2017). Worse still IPV victims tend to avoid assistance rendered by those individuals who are likely to report, therefore opt to stay in a toxic relationship.

Some studies on IPV against women provide several contributory factors to this form of violence. Beside cultural and religious beliefs, there are reports of factors such as alcohol and substance use by perpetrators, women's educational status (Bonnes, 16), and romantic jealousy. low self-esteem and suspected infidelity (Kyegombe, Stern & Buller, 2022; Londt,

2014; Martínez-León, Peña, Salazar, García & Sierra, 2017) contribute to IPV against women particularly in rural villages. In a study by Valabdass, Subramaney and Edge (2021),

2.8. Intimate Partner Violence intervention strategies in Limpopo Province

The reported cases of IPV against women in Vhembe districts are staggeringly high compared to other districts in the Limpopo province. This means that existing IPV intervention strategies may not be applied correctly, or they are ineffective to address the existing violence. This section conducts a scoping review of IPV interventions used in the Limpopo province and evaluates the perceived effectiveness in reducing IPV and enabling victims to cope with violence. The scoping review was essential in understanding IPV interventions used in the province and identifying the knowledge gaps on the effectiveness of the conventional strategies being used to deal with IPV at different levels of the affected district. The scoping review was intended to answer the following two questions:

1. What are the available Intimate Partner Violence interventions in Limpopo province?
2. What is the perceived effectiveness of such interventions to prevent IPV occurrences?

2.8.1 Scoping Methodology

A six-step scoping review process followed in this study was adapted from Roscher and van Wyk (2020) and Sav, Salehi, Mair and McMillan (2017) shown in Figure 2.1. The scoping review model has been widely used in several studies ((Piškur, Beurskens, Jongmans, Ketelaar, Norton & Frings, 2012; San, Hiremagalur, Muircroft & Grealish, L, 2017).

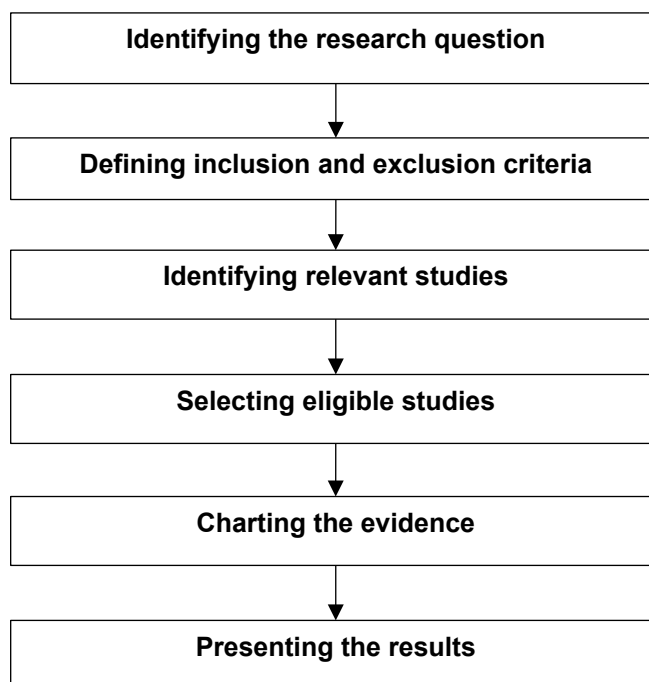


Figure 2.1: Scoping process

Adapted from Roscher & van Wyk (2020) and Sav, Salehi, Mair & McMillan (2017)

2.8.1.1 Identifying the question and objectives

The scoped literature review was intended to the following two questions:

- 1. What are the available Intimate Partner Violence interventions in Limpopo province?*
- 2. What is the perceived effectiveness of such interventions to prevent IPV occurrences?*

2.8.1.2 Defining inclusion and exclusion criteria

For an article to be included in the scoping review, it needed to measure or focus on specific aspects of IPV intervention and developed the study conceptual framework (for example, protection order, police case, reporting to family members, submissive, leaving partner, divorcing, negotiating, counselling, debriefing, etc). Only peer-reviewed journal and conference articles for studies conducted in Limpopo province, published between 2010 and 2022, written in English, involved human respondents/participants and explained a measure for IPV intervention were included. To consider different aspects being measured of IPV intervention, studies using quantitative, qualitative, and mixed-method approaches were used. Similarly, articles dealing with IPV intervention's effectiveness falling in the same publication period were included in the study. The review excluded articles that did not deal with IPV

interventions or dealt with IPV interventions outside the Limpopo province and were published before 2010.

2.8.1.3 Identifying relevant studies from databases

Articles used in the scoped review were obtained from online repositories which included Science Direct, MEDLINE/PubMed, Google Scholar and Mendeley. The articles that matched the research questions were found by using terms or expressions such as "IPV intervention in Limpopo", "IPV strategies used in Limpopo", "IPV and protection order in Limpopo", "Alleviating IPV in Limpopo, Vhembe", "Fighting IPV in Limpopo", "IPV coping strategies in Limpopo", "Common interventions strategies for IPV in Limpopo", "Effective IPV strategies in Limpopo", "Challenges of IPV strategies used in Limpopo", "Debriefing IPV strategies in Limpopo". The articles were downloaded from the databases and details were captured in a formatted Excel spreadsheet. The researcher repeatedly analysed the list of articles in the spreadsheet by applying the search parameters and deleted duplicate articles. Articles not meeting the inclusion criteria were removed and stored separately.

2.8.1.4 Selecting eligible studies

A systematic approach was used select eligible articles. The researcher scrutinised the abstract of each article looking at the IPV interventions as well as effectiveness. Each title of the article was screened to determine its eligibility for inclusion using the inclusion criteria. Duplicate articles were located and removed. The researcher conducted a full literature review focusing on IPV interventions and their effectiveness. The databases were supplemented with peer-reviewed articles from the open web that met the inclusion criteria.

2.8.1.5 Charting the evidence

A data charting form was produced to extract information about each article to enable the researcher to organise and synthesise information about each study. The following data about the article were collected: Authors' details, date of publication, the purpose and research questions used, the geographical context of the study, the population, study design and the number of participants involved, intervention type, the outcome of the intervention, key findings of the scoping review research questions, gaps still existing.

2.8.2 Presenting the results

After conducting a thorough search for relevant articles, 87 potentially relevant citations were located mainly from Google Scholar, PubMed, Springer, ScienceDirect and Mendeley, see

Figure 2.2. The articles were reduced to 61 after removing 16 duplications. The remaining 61 articles were screened and 30 articles mentioning the terms "Limpopo" and "Vhembe" only in the reference list or the article was a systematic literature review, were excluded. Further screening of 31 abstracts led to 13 articles being removed leaving only 18 eligible articles. The scoped literature was based on the 18 articles. The results show the scarcity of scholarly publications in peer-reviewed journals on IPV interventions in Limpopo province in general.

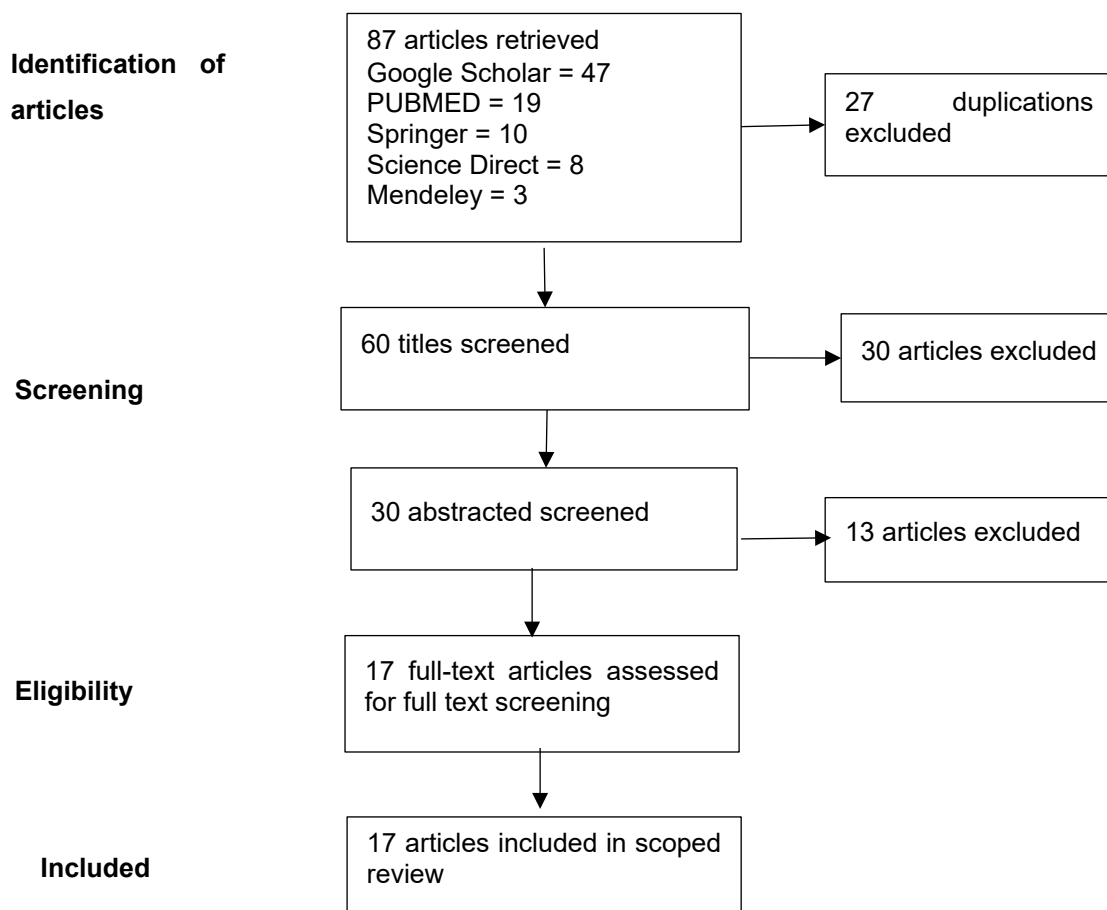


Figure 2.2: Study selection process

The 18 journal publications used in this review were published between 2010 and 2020. The distribution of the articles by date of publication is shown in Figure 2.3.

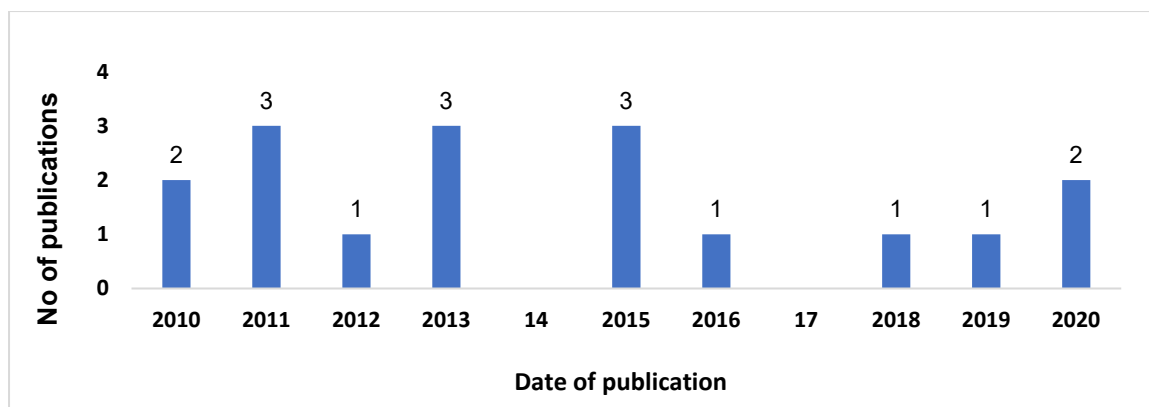


Figure 2.3: Distribution of articles by publication

The results show that very publications on IPV interventions in Limpopo were very low considering the prevalence of the type of violence reported. Much of the studies were on the causes of IPV and its effects on victims, especially unpublished dissertations, and thesis. All the literature sources used for the scoping review were from peer-reviewed journal articles.

Table 2.2 shows the distribution of the articles by district/province where the study was conducted. Most (11) of the articles were conducted for the whole Limpopo Province, 2 articles were for Vhembe district, 1 for Limpopo and Eastern Cape provinces, 1 for three provinces namely Limpopo, KZN and Northwest and the last 2 for national studies.

Table 2.1: Distribution of studies and authors with the place of study

District in Limpopo where the study was conducted	No of articles	Authors
Vhembe	2	1. Peltzer & Pengpid (2013); 2. Peltzera, Pengpidde, McFarlane & Banyinig (2013)
Limpopo	11	1. Hatcher, de Wet, Bonell & Strange et al. (2010) 2. Seedat, Van Niekerk, Jewkes, Suffl & Ratele (2010) 3. Jan, Ferrari, Watts, Hargreaves, Kim, Phetla, Morison, Porter, Barnett & Pronyk (2011) 4. Madzimbale, Khoza, Lebese & Shilubane (2011) 5. Kim, Ferrari, Abramsky, Watts, Hargreaves, Morison, Phetla, Porter & Pronykh (2011) 6. Mashudu Davhana-Maselesele, Madu, Wyatt, Williams, Makhado & Wong (2012) 7. De Koker, Mathews, Zuch, Bastien, Mason-Jones (2013) 8. Iyengar & Ferrari (2016)

District in Limpopo where the study was conducted	No of articles	Authors
		9. Pronyka, Kima & Abramsky (2018) 10. Knight, Ranganathan, Abramsky, Polzer-Ngwato, Muvhango, Molebatsi, M., Stöckl, Lees & Watts (2019) 11. Righi, Orchowski & Kuo (2020)
Limpopo & Eastern Cape	1	Dworkin, Hatcher, Colvin & Peacock (2015)
Limpopo, KwaZulu-Natal, and Northwest	1	Teffo-Menziwa, Mullick & Dlamini (2010)
National	2	Jama Shai & Sikweyiya, 2015; Metheny & Essack (2020)

The methodological design of the articles reviewed was as follows: 8 qualitative, mainly exploratory and case studies (Madzimbale, Khoza, Lebeso & Shilubane, 2011; Adworkin, Hatcher, Colvin & Peacock, 2015) and consultative workshops (Teffo-Menziwa, Mullick and Dlamini, 2010); 9 quantitative mainly descriptive surveys and cluster-randomised trials (Davhana-Maselesele, Madu, Wyatt, Williams, Makhado, Wong, 2012; Peltzer & Pengpid, 2013; Pronyka, Kima & Abramsky, 2018; Metheny & Essack, 2020); and 1 mixed-method (Hatcher, de Wet, Bonell, Strange, et al., 2010). The sample sizes used in the studies varied from 6 to 2265 participants, see Table 2.2.

Table 2.2: Distribution of publications by sample sizes

Sample sizes	No	Citations
Less than 20	1	Madzimbale et al. (2011)
20 - 100	6	Hatcher et al. (2010); Teffo-Menziwa et al. (2010); Davhana-Maselesele et al. (2012); De Koker et al.. (2013); Dworkin, et al (2015) Pronyka, Kima & Abramsky (2018)
101 -300	5	Peltzera, et al. (2013); Peltzer & Pengpid (2013); Shai & Sikweyiya (2015); Iyengar & Ferrari (2016); Righi, Orchowski & Kuo (2020)
851 -1000	2	Jan et al. (2011); Knight et al (2019)
More than 1000	3	Seedat et al. (2010); Kim, et al. (2011); Metheny & Essack (2020)

Most (11) of the sample sizes of the studies were randomly distributed mostly between 20 and 300 with a few studies utilising samples above 1000 participants. The sample size was important in the generalisations of the studies particularly the effectiveness of the IPV interventions. Among these studies, one was conducted with men only (Dworkin, et al, 2015)

and another with 3 women and 25 men who were traditional leaders (Teffo-Menziwa et al. 2010).

2.8.3 IPV interventions used in Limpopo Province

Reviewed literature shows that a few IPV intervention strategies were utilised in the province.

Table 2.3 shows the IPV interventions identified in the scoped review

Table 2.3: IPV interventions used in Limpopo Province (2010 – 2020)

Author(s)	IPV intervention	Notes
Seedat, Van Niekerk, Jewkes, Suffl & Ratele (2010)	IMAGE and training in violence against women sex and community action, and support of community activism	<i>Community-based intervention focusing on empowering women</i>
Hatcher, de Wet, Bonell, Strange, et al (2010)	IMAGE and skills teaching to women - Poverty reduction	
Jan, Ferrari, Watts, Hargreaves, Kim, Phetla, Morison, Porter, Barnett. & Pronyk (2011)	Intervention with Microfinance for AIDS & Gender Equity (IMAGE) programme for IPV victims to the empowerment of women through skills training using	
Shai & Sikweyiya (2015)	Empowering IPV and HIV victims through financial schemes and suitable training: Intervention with Microfinance for AIDS & Gender Equity (IMAGE)	
Iyengar & Ferrari (2016)	Poverty reduction through IMAGE and skills teaching to women	
Pronyka, Kima & Abramsky (2018)	Poverty alleviation or empowering women - microfinance program with gender and HIV training curriculum on HIV risk behaviour and IPV	
Knight, Ranganathan, Abramsky, Polzer-Ngwato, Muvhango, Molebatsi, Stöckl, Lees & Watts (2019)	Empowering IPV victims through microfinance programmes (for AIDS and Gender Equity)	
Madzimbale, Khoza, Lebeso & Shilubane (2011)	Workshops on sexually- transmitted infections and IPV	<i>Community Intervention strategies</i>
Teffo-Menziwa, Mullick & Dlamini (2010)	GBV capacity building of traditional leaders	<i>targeting men, women, and</i>

Author(s)	IPV intervention	Notes
De Koker, Mathews, Zuch, Bastien & Mason-Jones (2013)	The Safe Dates and Stepping stones interventions, Shifting Boundaries, Coaching, Community activities	<i>community leaders</i>
Shai & Sikweyiya (2015)	Steppingstone/ Creating Futures	
Adworkin, Hatcher, Colvin & Peacock (2015)	One Man Can'' (OMC) rights-based gender equality and health intervention program (Gender-Transformative and anti-violence program)	<i>Community-based strategies focusing on men</i>
Peltzer & Pengpid (2013)	Reducing the problem of drinking and drug use among men	
Davhana-Maselesele, Madu, Wyatt, Williams, Makhado, Wong (2012)	Counselling and support for IPV survivors	<i>Counselling of Victims for women and man</i>
Righi, Orchowski & Kuo (2020)	Integrated IPV/HIV interventions	
Peltzer, Pengpid, McFarlane & Banyinig (2013); Peltzer & Pengpid (2013)	A protection order against men	<i>Legal intervention strategies targeting men</i>
Metheny & Essack (2020)	Policies addressing GBV and IPV	

Most (12) of the publications reviewed focused on community-based IPV intervention strategies where women were the main participants (Seedat et al., 2010; Procyk, Kima & Abramsky, 2018; Knight et al., 2019). A few studies (5) focused on the conventional IPV strategies such as counselling victims and perpetrators (Davhana-Maselesele et al., 2012; Righi, Orchowski & Kuo, 2020), use of policies (Metheny & Essack, 2020) and protection order (Peltzer et al., 2013; Peltzer & Pengpid (2013)). Three community-based interventions utilised in these studies included those that sought to address IPV by poverty alleviation and empowering women, capability building of women, men and community leaders in IPV and gender-based violence against women, and those that targeted IPV perpetrators. Eight studies conducted between 2010 and 2019 were dedicated mainly to IPV intervention modelled on IMAGE and training meant to reduce poverty among women in Limpopo rural villages (Seedat et al., 2010; Hatcher, et al., 2010; Kim, et al., 2011; Jan, et al., 2011; Shai, & Sikweyiya, 2015; Iyengar & Ferrari, 2016; Pronyka, Kima & Abramsky, 2018; Knight et al., 2019). The IMAGE project in Limpopo and other parts of South Africa is widely reported in various systematic review studies on IPV. Three studies report the implementation of community-based intervention strategies targeting men, women, and community leaders to

capacitate them in IPV and other GBV issues that disadvantage women (Teffo-Menziwa, Mullick & Dlamini, 2010; Madzimbale et al., 2011; De Koker, et al., 2013). These studies utilise workshops and other education strategies that raise IPV and GBV awareness among the rural populations through the victims, perpetrators, and traditional leaders. One of the last two community-based IPV interventions targets men, for example, the One Man Can (OMC) is a gender-transformative and anti-violence programme used to conscientize men about the ills of IPV (Adworkin, et al. 2015). The last community-based IPV intervention sought to reduce violence by encouraging men to reduce alcohol intake (Pelzer & Pengpid, 2013). This IPV intervention has been widely reported in several studies outside the scope of this study (Coughlin, 2017).

The other IPV intervention used in the province is the counselling of the victims who could have visited clinics or reported to the police (Davhana-Maselesele et al., 2012; Righi, Orchowski & Kuo. 2020). Very few studies were conducted on the viability of this type of IPV intervention in the province. There are pockets of studies reporting on the use of protection orders for IPV intervention perpetrators, particularly in the Vhembe district (Peltzer et al., 2013; Peltzer & Pengpid, 2013). This legal IPV intervention was mostly used by victims living closer to police stations and targeted abusive men. The least reported IPV intervention strategies are policies and legal instruments for addressing GBV and IPV (Metheny & Essack, 2020).

The key findings for IPV interventions used in the Limpopo province were that a variety of community-based strategies were used depending on the nature of IPV. The community-based IPV interventions sought to reduce poverty among women by training in income-generating projects. The IMAGE was used to economically empower women by lending them money used to start projects that kept them busy most of the time. The duration of IPV intervention in previous studies is shown in Table 2.4.

Table 2.4: The duration of the IPV intervention varied in each study

Duration of IPV intervention	No of publications	Citations
Less than 6 months	9	Madzimbale et al. (2011); De Koker et al. (2013); Davhana-Maselesele et al. (2012); Peltzer & Pengpid (2013); Peltzer et al. (2013); Dworkin et al. (2015); Shai & Sikweyiya (2015); Knight et al (2019); Righi, Orchowski & Kuo (2020)
6 - 12 months	2	Hatcher et al. (2010); Seedat et al. (2010)
13 - 24 months	4	Teffo-Menziwa et al. (2010); Kim,et al. (2011); Jan et al. (2011); Pronyka, Kima & Abramsky (2018)
24 - 36 months	2	Iyengar & Ferrari (2016); Metheny & Essack (2020)

The findings in Table 2.4 show that most (9) of the studies that implemented IPV interventions had a duration of fewer than 6 months, and the effectiveness of the intervention could have been prematurely determined thereby leading to unreliable conclusions on long-term effects. In 4 studies, the duration of the intervention strategies took between 13 and 24 months, while in the last two studies, the duration was between 24 and 36 months. These durations were dependent on the purpose and type of study which was conducted. Studies which implemented IMAGE and capacity building took more time to implement IPV and HIV interventions and tended to be case studies or consultative workshops (Kim, et al., 2011; Jan et al. 2011; Pronyka, Kima & Abramsky, 2018; Iyengar & Ferrari, 2016; Metheny & Essack, 2020). Such studies provided the IPV victims to acquire skills in financial management and gender training while reducing their exposure to violence from their partners (Iyengar & Ferrari, 2016).

2.8.4 Perceptions about the effectiveness of the IPV intervention used

The findings for the perceived effectiveness of the IPV interventions used in the Limpopo province are not conclusive as very few studies were longitudinal and used very small populations. Key findings on the perceived effectiveness of the intervention used are shown in Table 2.5.

Table 2.5: Perceived effectiveness of IPV intervention in Limpopo Province

IPV Intervention used	Perceived IPV intervention	Citations
IMAGE, poverty alleviation or empowering women financially, a structural intervention of combined group-based microfinance with a gender and HIV training curriculum on HIV risk behaviour and intimate partner violence	Effectively uses group support to reduce IPV by 55% over a long time by successful building critical consciousness on violence	Hatcher et al. (2010); Jan et al. (2011); Iyengar & Ferrari (2016); Pronyka, Kima & Abramsky (2018); Knight et al (2019)
Financial empowerment of women through training and IMAGE	Economic empowerment reduced IPV against women. Improved decision-making and management of conflicts	Kim, et al. (2011)
IMAGE and gender training in violence against their sex and community action, and support of community activism	Decreased rape significantly but the short-term effect on IPV	Seedat et al. (2010); Shai & Sikweyiya (2015)
Integrated IPV/HIV interventions,	Promising results for IPV/HIV risk reduction for short term	Righi, Orchowski & Kuo (2020)
Counselling and support for the survivors	Counselling and support for the survivors of IPV and its effects. Not much effective as it excludes perpetrators	Davhana-Maselesele et al. (2012)
Workshops on sexually- transmitted infections with IPV victims	Reduced backlash and exposure of women to violence	Madzimbale et al. (2011)
GBV capacity building of traditional leaders	Raised Awareness of IPV and GBV	Teffo-Menziwa et al. (2010)
The Safe Dates and Steppingstone interventions, Shifting Boundaries, Coaching, Community activities	Short-term positive effects on reduction of violence	De Koker et al.. (2013)
Encouraging men to reduce problem drinking and drug use	Ineffective	Peltzer & Pengpid (2013)

IPV Intervention used	Perceived intervention	IPV	Citations
One Man Can' (OMC) is rights-based gender equality and health intervention program (Gender-Transformative and anti-violence program)	Effective in changing attitude of men. Reduced IPV in medium-term		Dworkin et al. (2015)
IPV prevention interventions Policies - Presidential response to GBV	Somewhat effective in reducing IPV		Metheny & Essack (2020)
Protection orders	Effective in reducing IPV in the short term		Peltzera et al. (2013); Peltzer & Pengpid (2013)

All studies combining IMAGE and gender training, or skills teaching of women in the province report a positively perceived effectiveness of the interventions in reducing IPV in the selected districts in the province. Some studies report a reduction of IPV by 55% over 24 months as partners involved in the poverty alleviation programmes as they developed a critical consciousness about violence and the need to avoid it (Hatcher et al. 2010; Jan et al. 2011; Iyengar & Ferrari, 2016; Pronyka, Kima & Abramsky 2018; Knight et al, 2019). The IMAGE enabled women to get support from group members they worked with in the financial schemes. According to Kim, et al. (2011), economic empowerment through IMAGE led to a reduction in IPV against women because it improved decision-making and management conflicts with their male partners. The IMAGE and gender training programmes are perceived as being effective for medium to long term in IPV reduction in the province. Furthermore, literature shows that a hybrid of IMAGE and gender training in violence against women and community action/support of community activism had short to medium-term effectiveness in reducing rape by intimate partners (Seedat et al. 2010; Shai & Sikweyiya, 2015). IPV interventions such as counselling, workshops and capacity building are reported as having short-term effects once the perpetrators are left with the victims. A study by Madzimbale et al. (2011) reports that workshops on sexually transmitted infections with IPV victims led to the reduction of backlash and exposure of women to violence. Similarly, Davhana-Maselesele et al. (2012) concluded that counselling and support for IPV victims were very effective during the initial phase of the intervention, and this weakened with time as the victims and perpetrators reverted to their normal life resulting in the repeat of the violence. This IPV intervention had a short-lived effect as the partners were bound to get together during the support and counselling. GBV capacity building of traditional leaders is reported to have been effective in raising awareness of IPV and GBV among traditional leaders (Teffo-Menziwa et al., 2010). This IPV intervention was

effective in capacity building with the leaders of communities in which violence occurred. The capacity building was intended to change the attitudes of traditional leaders on IPV and GBV by accepting women as being important members of the family and communities (Teffo-Menziwa et al., 2010). OMC was found to be effective in changing the attitudes of men towards women thereby reducing IPV in the medium to long term (Dworkin et al., 2015). Unlike other studies, the OMC IPV intervention derives its effectiveness because it focuses on men, the perpetrators of IPV to change attitudes (Dworkin et al., 2015). OMC a gender-transformative intervention strategy has been fused with strategies that target substance abuse by men, community activities which encourage men to accept women as equals such as steppingstones, shifting boundaries and coaching which allows men to work together with their partners (De Koker et al., 2013). Encouraging men to reduce alcohol intake has its effectiveness in reducing IPV likely to occur when men are in a drunken state (Peltzer & Pengpid, 2013). Separate studies by Peltzer et al. (2013) and Peltzer & Pengpid (2013) concluded that protection orders were effective for first IPV offenders and ineffective with repeated abusers who deliberately violate the order. The findings show that most of the IPV intervention strategies were perceived as being effective over different timespans and diminished when the support was withdrawn (Righi, Orchowski & Kuo, 2020). It is also evident from the studies that some of the IPV interventions were just projects conducted by non-governmental organisations and were unsustainable in the long run, particularly those of the IMAGE. They did deal with women instead of men, the perpetrators of IPV.

2.8.5 Discussions of findings

The findings show that most studies focus on poverty alleviation among IPV victims using the IMAGE and gender training programmes. The programmes were run in rural communities in which women were lent money to start income-generating programmes developing skills in the management of small projects. While reducing poverty, the projects were intended to improve decision-making among IPV victims, a skill that could be essential when confronted by violent partners (Seedat et al., 2010; Shai & Sikweyiya 2015; Pronyka, Kima & Abramsky, 2018; Knight, et al., 2019). The IMAGE IPV intervention sought to reduce violence against women by reducing the time they spent with violent unemployed partners (Schneider, Harknett and McLanahan, 2017). Therefore, an increase in income-generating activities for women increases the separation of partners to reduce violence as this reduces the time partners spend together arguing over trivial matters. Besides reducing poverty and changing perceptions of gender norms among women, the hybrid of the IMAGE and gender training in violence programs was found to be effective in empowering women by changing attitudes to violence and improving decision-making skills (Jan et al., 2011; Schneider, Harknett and

McLanahan, 2017; Knight et al., 2019). A study by Abramsky, Watts, Garcia-Moreno, Devries, Kiss, Ellsberg, et al. (2011) found that the positive effects of taking part in microfinance and gender training intervention were a motivation for women of all ages to improve their economic status and relationships with their partners. Similarly, Brody, Hoop, Vojtkova, Warnock, Dunbar, Murthy et al. (2017) found that loan groups supporting participatory gender training were able to provide important social support to improve self-esteem and that encouraged IPV victims to question existing or new relationship power imbalances and boost confidence to leave abusive partners or spouses. This implies that IPV victims who perceived the training as having a positive effect on their relationship were motivated to attend more sessions than those who saw the pieces of training as unhelpful.

The positive effects of the IMAGE and gender training programmes IPV interventions were short-lived once the schemes were discontinued. Furthermore, this IPV intervention target women instead of men. Some studies contend that an increase in financial independence by women increased violence in other areas where they interacted with violent partners (Aizer 2010; Pronyka et al., 2018). The IMAGE and other related programmes focused much on unemployed IPV victims while neglecting those employed victims. According to Matseke, Rodriguez, Peltzer and Jones (2016), some IPV interventions are rendered ineffective diverse types of IPV that need to be alleviated. In some cases, inappropriate IPV interventions are not informed by research and are not aligned with the problems being addressed (Matseke et al., 2016). This could explain why the same type of violence recurs despite implementing income-generating programmes to alleviate poverty and empower women. According to Mannell, Willan, Shahmanesh, Seeley, Sherr and Gibbs (2019), IPV empowering women excluding men can be construed as encouraging women to defy men and leading to more violence.

Counselling and support for the survivors reported in some studies were effective with a small group of victims however it was hampered by delays in the screening of physically-assaulted women (Davhana-Maselesele et al., 2014). A limited number of counsellors in trauma centres is another major cause of the ineffectiveness of this IPV intervention. According to Davhana-Maselesele et al. (2014), the Limpopo Province experiences an acute shortage of trained healthcare personnel needed to deal effectively with trauma due to sexual and physical assault. These persistent shortages of mental healthcare practitioners mean that not every sexually or physically assaulted woman has an opportunity to be seen by a psychologist (Davhana-Maselesele et al., 2014; Righi, Orchowski & Kuo; 2020). Most victims continue to suffer from trauma without proper assistance from psychologists.

Gender-transformative IPV intervention, involved OMC workshops designed and implemented by Sonke throughout South Africa using a rights-based approach (Dworki et al., 2012). The advantage of OMC IPV intervention is that it focuses on men by providing spaces for critical reflection on masculinities and gender relations by pairing participatory workshops facilitated by men (Mokganyetji, Anderson & Stern, 2015). Another strength of the OMC model is that it relies on mobilisers, and community members tasked with finding ways of providing support to community action teams (CATs) (Mokganyetji, Anderson & Stern, 2015), a group of community volunteers (Palitza, 2009; Peacock, 2013). During the sessions men reflect upon human rights, women's rights, and how masculinities are defined, practised, reified, and can be challenged in relationships, communities, and broader society (Dworki et al., 2012). The effectiveness of OMC could be enhanced by community action teams (CATs) which enable self-directed local groups of women and men to create action plans and participate in civil activism against gender-based violence at the local level (Mokganyetji, Anderson & Stern, 2015; Wright, 2014). Mokganyetji, Anderson & Stern (2015) views OMC as an effective individual and interpersonal behaviour change approach which needs continuous application in rural communities. OMC intervention on its own has short-term effects on reducing IPV in rural communities (Dworki et al., 2012). OMC has been touted for improving anger management (Dworkin et al., 2012). The finding by Dworkin et al. (2012) shows that men from both Limpopo and Eastern Cape provinces who participated in OMC workshops affirmed the effectiveness of the IPV intervention in assisting them to manage their anger towards their wives and other people.

South Africa is renowned for good policies and guidelines in the health and criminal justice systems as well as some areas of excellent practice, but the overall implementation remains a challenge in solving GBV and IPV against women (Seedat et al., 2010). One of the key responses to IPV in South Africa is the use of social and behavioural policies and programmes designed to address both contextual drivers and individual behaviours likely to put women at increased risk (Mokganyetji, Anderson & Stern, 2015; Parry, 2005; Redpath, Morrell, Jewkes & Peacock, 2009). To curb violence against women, President Cyril Ramaphosa announced a five-point emergency plan to address GBV in South Africa (Mbatha, 2019; Khumalo, 2019; Cohen & Metheny & Essack 2020).

Despite these developments, South Africa still experiences low levels of prosecution and conviction in domestic violence cases and the frequent failures by the police to serve and enforce protection orders, exposing survivors to repeated abuses and resulting in the violation

of women's fundamental rights, the UN women's rights committee has found (CEDAW, 2021). This has resulted in South Africa failing to comply with its obligation to effectively investigate, prosecute and punish cases of domestic violence, and provide systematic and effective capacity building for the judiciary and law enforcement bodies, thereby violating the right of South African women to live free from domestic violence (CEDAW, 2021). The failure of the police and legal system to provide necessary IPV intervention means that communities have to mobilise and put in place measures to fight GBV and IPV. IPV interventions based on legal systems seek to eradicate violence without addressing the root cause of the pandemic and this results in frequent failure (Department of Social Development, 2014). Studies conducted outside the Limpopo province document additional IPV interventions to the ones already discussed. The crafting of new laws and policies to tackle GBV applies regionally and globally. For example, several African countries signing up and ratifying various international conventions shows commitment to eradicating GBV and other forms of violence against women. (Beijing Platform for Action [BPFA], 1995; UN Resolution 1325 on Women, Peace and Security, 2000; and the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, 2003). The main focus of the first generation of IPV interventions is on the provision of support services to survivors of violence and seeks to reduce perpetrators' impunity through the existing justice system (Ellsberg, Arango, Morton, Gennari, Kiplesund, Contreras, & Watts, 2015). However, these IPV do not prevent violence as they are corrective and not deterrent. Some IPV interventions address the physical and psychological needs of survivors, shelters, counselling services and victim empowerment were established (Mshweshwe, 2018) but victims tend to ignore such services in preference for support from family and friends.

A study by Mannell, Willan, Shahmanesh, Seeley, Sherr & Gibbs (2019) identifies three flaws in some IPV interventions being used in South Africa: 1) developing interventions without the meaningful contribution of both young women and men; 2) interventions focus on addressing individual risk factors rather than broader social and structural contexts of being a woman, and 3) intervention models fail not adequately account for changes in gender norms and relationships in many Southern African countries. This would mean that most IPV interventions are designed from very few participants and save the interests of very small groups of people most of which may not be the affected individuals. Some IPV and GBV interventions fail to bring about behavioural, and cultural change among men regarding the rights of women but perpetuate well-entrenched gender and age-related inequalities that marginalise women. According to Mannell et al. (2019) GBV and IPV, interventions fail to address the role of new

technologies in transforming romantic interactions and proving new chances to reinforce gender inequalities and violence against women.

Due to the ineffectiveness of most conventional and imposed community-based IPV interventions in the province, most studies recommend a rethink and major shift from these programmes to home-grown preventive strategies that address the underlying causes of IPV in a holistic and coordinated manner. A holistic approach requires interventions spanning the continuum from prevention and protection to response and long-term care and support (Department of Social Development, 2014), something which current approaches fail to provide. Long-term and effective strategies need to be devised by affected communities targeting the IPV perpetrators to bring about behavioural change and the acceptance of women and important members of the communities.

2.9 Conclusion

This chapter provided a detailed explanation of IPV, its prevalence in South Africa and the Limpopo province, and the Vhembe district. Factors contributing to IPV have been explored. A scoped review of literature has been given focusing on IPV interventions and their effectiveness in Limpopo province. Literature on IPV intervention in Limpopo is scarce as indicated by 17 journal studies used. The most popular IPV used were found to be community-based, intended to reduce poverty, and empower women financially, and gender-transformative which seek to change the perception of men and women about IPV. Legal and policy IPV interventions seem to be used but have challenges. All the IPV interventions are effective for the short term because they are not home-grown and are implemented without participants having full knowledge. The studies recommend a shift from prescriptive IPV interventions to those which are homegrown. Furthermore, IPV interventions have been found to be focusing much on victims instead of perpetrators who either go unpunished because of not being reported, or the justice system requires too much from victims forcing them to quit.

Due to challenges in the existing conventional IPV interventions in addressing the causes of violence and protection of victims, the study becomes relevant in designing a home-grown strategy suitable for rural areas in the Vhembe district. Therefore, the next chapter presents a detailed research methodology and design to be used to develop a home-grown strategy suitable for rural areas in the Vhembe district.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

Chapter 2 has presented a detailed literature review on IPV, its possible causes as well as the intervention strategies in a broad overview, as well as encompassing Limpopo province in particular. To further understand IPV issues in the province, there was a need to collect data from the victims and this calls for a systematic process of conducting the research, the research design and methodology. This chapter outlined the study design. The study setting was described. The study population was stated, the measurement instrument for collecting data was outlined, the pre-test procedure was detailed, trustworthiness, the plan for data collection, the plan for data management and analysis, as well as ethical considerations, delimitation of the study and limitations of the study and plans for dissemination and implementation of results.

3.2 Research Approach

This study used a mixed-method approach. As a method, a focus is placed on collecting, analysing as well as mixing both quantitative and qualitative data in one single study or even a series of studies. Its central basis is the use of quantitative and qualitative approaches to provide a much broader understanding of a research problem than either approach on its own (Creswell & Plano Clark, 2017). The study used an explanatory sequential mixed method design. According to Creswell et al (2017), encompasses first collecting quantitative data and then moving on to collecting qualitative data to help elaborate on the quantitative results. The study used an explanatory sequential mixed method design. According to Creswell et al (2017), encompasses first hand collecting quantitative data and then moving on to collecting qualitative data to help elaborate on the quantitative results. The study used an explanatory sequential mixed method design. According to Creswell et al (2017), encompasses first hand collecting quantitative data and then moving on to collecting qualitative data to help elaborate on the quantitative results. In a nutshell, the mixed methods encompass integrating quantitative and qualitative data collection and analysis into a single study or a programme of inquiry (De Vos et al, 2018). Therefore, data were integrated, or mixed at some points in the research process.

A combination of approaches was used because neither alone could address the study objectives adequately. This approach facilitated the collection and comparing of data from these two methods. Therefore, it ensured the development of the appropriate strategy that empowers women against IPV occurrences in the Vhembe district. The rationale for this particular approach was that the quantitative data including the results thereof provide a broader picture of the research problem; more analysis, specifically through qualitative data collection is needed to refine, explain or extend the observed problem from victims' perspectives. The qualitative method allows participants to give views in their words, rather than a choice between predetermined responses. This enabled the researcher to understand the factors at hand that contribute to obtaining and understanding factors that contribute to IPV violence in the district of Vhembe. Accordingly, this study was conducted in two phases. Phase 1a employed a quantitative methodology, Phase 1b utilised a qualitative methodology and Phase 2 is the strategy development.

3.3 Phase 1a Quantitative Approach

An explanatory mixed method design has been adopted for this study. The study used the quantitative approach to enable the researcher to describe the knowledge and the attitude and behavioural skills regarding intimate partner violence in this study. It facilitated the comparison to be made between demographic variables and knowledge, attitudes and behavioural skills. Due to the type of data needed for the initial phase of the empirical study, and the time factor, the survey strategy was chosen to enable the researcher to collect data at a single point in time, to maximise the response rate. Furthermore, the descriptive design was used to describe the knowledge, attitudes and skills/behaviours regarding intimate partner violence.

Phase 1 is a quantitative approach which was utilised to achieve the following objectives:

- To measure the level of general knowledge regarding intimate partner violence among IPV victims in the Vhembe district.
- To describe the victim's motivational attitude towards the acquired IPV information to act against any form of IPV behaviour in the Vhembe district.
- To assess the behavioural skills used by victims in dealing with any IPV occurrence.

3.4 Setting of the study

The study was conducted at the Thohoyandou Victim Empowerment Centre (TVEP) centre, which is in the Vhembe district, Limpopo province of South Africa (See figure 2). Vhembe is a district found in Limpopo one of the nine provinces in South Africa. Vhembe district is the northernmost district of South Africa sharing its northern borders with the Beitbridge district in Matabeleland South, Zimbabwe. The population of the Vhembe District is estimated to be between 1 232 218 and 1 302 113. The females account for close to 53.3% of the district population and the males make up 46.7%. Being mainly rural district means that 80% of the population, particularly females stay in rural communities (Limpopo Provincial Government, 2019). The population sustain itself through several activities and products including subsistence fruit and plantation farming, selling products in street, the government disbursed social grants and formal employment by private, public and information organisations (Limpopo Provincial Government, 2019; Madzimbale, et al., 2011).

For health services, the general population in the district relies mostly on public health institutions which are funded by the provincial and national governments. Less than 18% of the general population in the district depends on private health insurance. this means that at least 82% of the population depends on government-funded health care facilities (Limpopo Provincial Government, 2019). There are 8 hospitals in Vhembe District of which one is a specialized mental health institution, that only admits mental health care users (Limpopo Provincial Government, 2019). One regional hospital together with six district hospitals respectively provides services to more than 1.2 million people (Limpopo Provincial Government, 2019). Most of the households in the District, particularly in rural areas are headed by females who usually go job seeking in urban and peri-urban areas. The area is faced with infrastructural backlogs for water, sanitation and electricity which impact negatively on the health of these communities. The poor road infrastructure influences reasonable response times for vehicles such as ambulances, mobile clinics, and police vehicles (Limpopo Provincial Government, 2019).

Vhembe District is under the governance of tribal chiefs and elected local government. The district has an extremely elevated unemployment rate, sitting at 38.7%, 3.6 being the deprivation index, and also according to the Community Survey 2018, over 12% of households are living with an annual income below R4, 800 or less than R400 per month(Limpopo Provincial Government, 2019). The Integrated Victim Empowerment Policy (IVEP) forms a part of the strategic efforts of the South African government to combat crime and bring

therefore a peaceful crime-free country. The IVEP recognises the significance of victims and all stakeholders, in a combination of those in the public and private spheres, who deliver services to victims. The policy, therefore, provides for the coordination of all activities and efforts by various government departments and civil society. It creates a framework to guide and inform the provision of integrated and multidisciplinary services to address the needs of victims of violent crime (VEP, 1998).

The TVEP centre's purpose is to allow the victims of crime to play a greater and more meaningful role in the criminal justice system, helping them to cope with the consequences of their victimisation, and equipping them with knowledge and skills to become resistant to repeat victimization (VEP, 1998). Further, Thohoyandou Victim Empowerment Programme (TVEP) puts its focus on providing prevention, empowerment as well as support services in five thematic areas: namely HIV/AIDS, child abuse, domestic violence, sexual assault, and lesbian gay bisexual transgender or intersex (LGBTI) community/ minorities. The TVEP works with the National prosecution authority, the South African Police Service, the Department of Health, the Department of Justice and the Department of Social Development. The Thohoyandou victim empowerment centre runs two trauma centres which are housed at Donald Fraser and Tshildzini hospital. Further, they have operational victim empowerment help desks in rural clinics such as Xigalo, Vhurivhuri, Makonde, Mukula, Ha-Radali, Phiphidi and Fondwe.

Domestic cases are normally opened by the police but most clients walk into trauma centres where they are assisted to open cases and undergo a medical examination. Victims have received victim support at the trauma centre and are provided with crisis intervention to talk the matter through. The victim supporter is well trained to ensure that the situation is contained and the victim is guided to decide on his or her options. The centre is bankrolled by local and international funding; local funders are the Nelson Mandela Children's Fund and the Department of Social Development and Comic relief (an international funder). The centre staff is comprised of a project manager, legal officer, protection order officer and court monitors. The map showing the study area is presented in Fig 2.



Figure 3.1: Vhembe district map

3.4.1 Population

According to Garg (2016) population refers to the entire collection of units, entities or people on which a study focuses on. The target population consisted of only women who were the victims of IPV in the Vhembe District. There are about 792 women who are victims (TVEP,2019). The sampling frame for IPV is shown below in Table 2.1

Table 3.1: Victims of Intimate Partner Violence in Vhembe district

Category of women who are victims of IPV in Vhembe District, August 2019	Number of women who are victims of IPV in Vhembe District
Adults (18-59 years)	746
Elderly 60 years and 65	46
Total	792

Source: Thohoyandou Victim Empowerment Centre, 2019

3.4.2 Sampling

“Sampling is the process of selecting cases to represent an entire population so that inferences about the population can be made” (Grove & Gray 2018:12). A sample is a small segment of a population such as a group of events, cases or people with certain qualities

matching those that the researcher expects to get data to answer research questions. A sample is usually selected by the researcher based on certain criteria. Census sampling techniques are what have been used to select the participants. The purpose of a sample is to enable the researcher to establish facts about the sample that will also be true for the population

3.4.2.1 Size of research sample in the quantitative phase

In the quantitative phase, the sample size was 792 domestic violence victims, coincidentally, the total population of the study.

3.4.2.2 Sampling of the participants

The sampling technique used in the quantitative phase of the study was the census technique, which included all the IPV victims available in the targeted that was being targeted population of the study. The census sampling technique targeted all 792 domestic violence in the Vhembe district. This technique was conveniently used because there were few documented cases of IPV victims that were accessible to the researcher. The IPV victims who participated in the were obtained from the TVEP database system. By using a sample of 782 IPV victims, the researcher intended to increase the response rate as well as make the sample as representative as possible of the target populations. This was also supported by the notion that the bigger the sample the more likely the accurate the results were to be obtained due to the involvement of respondents with the right knowledge, motivation and behaviours regarding IPV within the Vhembe district.

Inclusion criteria

- Women aged 18-65 years who are victims of IPV and
- Reported the case at the TVEP centre
- Women who were willing to be participants in the study
- From Vhembe district

Exclusion criteria for participants

- Women victims who are below 18 years and above 65 years because the target population were women who were between 18 to 65 years of age

- Women who are not were willing to be participants in the study because of their personal reasons
- Women who are staying outside the borders of the Vhembe district

3.4.3 Data collection instrument

A self-administered questionnaire was used to collect the data. The tool was adapted from different studies (Goodman, Dutton, Weinfurt, & Cook, 2003; Ellsberg & Heise, 2005). The questionnaire had closed-ended questions and was developed concerning the literature review, study objectives and theoretical framework. The questionnaire has 4 sections described here. Section one focused on the demographic information of participants, section 2 on measuring the level of knowledge possessed by women towards IPV, section 3 on assessing the attitude of women towards IPV and section 4 determined the strategies that were used by women to deal with domestic violence. A questionnaire was therefore developed in English and later translated to Tshivenda and Xitsonga because these are the main languages in Vhembe District (**See Appendix 3**). The questionnaire was translated by Tshivenda and Xitsonga language practitioners from the Mathivha centre for African languages at the University of Venda. The knowledge and behavioural skills use yes/ no responses whereas the attitude section used four points Likert-type scale with strongly agree to strongly disagree.

3.4.3.1 Pre-test

A pre-test is the trial administration of a newly developed instrument to identify problems (Flick, 2017). A pre-test was done at Vhembe district Thuthuzela centres. The main aim of conducting a pre-test was to check if participants had a clear understanding of the questions in the questionnaire. On 10% of the total participants, a pre-test was conducted. These participants were not included in the study. The results of a pre-test were used to rephrase a questionnaire where necessary. Useful information gathered in pretesting was included in the study.

3.4.3.2 Reliability and Validity of the measuring instruments

The issues relating to the validity and reliability of the study design and data collection tools which were used during this study are discussed below:

- **Face validity**

Face validity refers to the extent to which an instrument looks valid (Lo Biondo & Haber, 2017). Each question or item on the research instruments must have a logical link with an objective. The establishment of this link is an indication of the validity of the instruments. The greater the link, the higher the face validity of the instrument. Face validity of the questionnaire was done by experts in IPV at university of Venda to evaluate supervisors in the Department of Public health. The questionnaire was presented to the School of Health Sciences Higher Degrees Committee and the University Higher Degrees Committee for assessment so that inputs can be given and allow the researcher to make corrections to the questionnaires.

- **Content validity**

Content validity refers to the extent to which the items in a data collection instrument accurately measure the construct that is being investigated (Grove & Gray, 2018). Several items for measuring factors influencing IPV were produced from several sources. Research questions and objectives were used to determine the items for each construct. Most of the constructs were derived from the literature review on IPV and this was supposed to increase content validity. Each item, question and statement on the questionnaire addressed a construct in IPV. After the design of the questionnaire, supervisors and expert reviewers assisted with content validity. The design of the new instrument began with a thorough conceptualization of the construct so that the instrument can capture the full content domain.

- **Reliability**

Reliability is the consistency with which an instrument measures the attribute (Etikan & Bala, 2017). The stability of an instrument is the degree to which similar results are obtained on separate occasions. Reliability was ensured during this study by using the same data collection tools on participants. The same questionnaires were used for all participants. Piloting of the data collection instruments was conducted before data collection to ensure reliability and corrections were made when necessary. The researcher arranged a suitable time for data collection with the managers to avoid interruption of participants during data collection. Furthermore, some of the tools adapted for this study bear high levels of reliability (Goodman, Dutton, Weinfurt, & Cook, 2003; Ellsberg & Heise, 2005).

3.4.3.3 Recruitment of Participants

Firstly, permission was sought and once granted by relevant authorities before data collection, the researcher scheduled appointments with the Thohoyandou Victim Empowerment Centre management to collect data. The researcher was assisted by the staff at the centre to recruit intimate partner violence clients who meet the sampling criteria. This was done because violence against women by their partners is still a sensitive topic to be discussed in rural South Africa, and some clients may not like to be directly approached by a researcher. After the staff had approached the clients and they agree to participate in the research, a meeting was arranged with the researcher. The centre staff explained the study to each client. The information sheets were provided to clients who can read. Further, the researcher introduced herself and her assistants to prospective participants, who explained the purpose of this study in detail. Consent forms were issued to each prospective participant. The researcher asked the participants about the most convenient date and time for them to complete the questionnaire.

3.4.3.4 Data collection procedure

During the data collection stage, the researcher and assistants distributed questionnaires to the respondents a week after making an appointment. Each respondent was given approximately 45 minutes to complete the questionnaire. The researcher and the research assistants delivered or distributed the questionnaires to the participants. Respondents completed questionnaires as per instructions and handed them back after completion.

3.4.5 Data management and analysis

The researcher followed strict data management measures suggested by Nghitanwa (2018) to safeguard the whole research process so that the rights, privacy and confidentiality of the participants were upheld. Data for this study were collected from respondents using questionnaires and were captured into the SPSS software program version 27.0. Upon the completion of the capturing, raw data was cleansed to remove wrong entries and verified for consistency and completeness values to ensure integrity (Nghitanwa, 2018). To ensure accuracy in data capturing, the capturing process was given ample time of four weeks. This was done by the researcher in a secluded office to ensure the confidentiality and privacy of data and its sources. The database was created and cleaned for missing data before running

the statistical analysis. Cross tabulations and logistic regression were utilised to determine associations of participants' socio-demographic characteristics with knowledge, attitude and behavioural outcomes. Logistic regression was performed to determine predictions of demographic variables with participants' knowledge and attitude scores. Data analyses were performed using the software Statistical Package for the Social Sciences (SPSS) version 26.0. Significance level is set at < 0.05 .

3.5 Phase 1b Qualitative Approach

The objectives of phase 1b were informed by the findings of phase 1a. The objective of phase 1a relied on the quantitative findings. In the explanatory sequential design mixed method, the data are collected over a period of time in two consecutive phases. The researcher collected and analysed the quantitative data first.

3.5.1 Study Design

Descriptive, explorative, and contextual designs were used. The approach describes factors that predispose women to IPV in the Vhembe district. The explorative approach was aimed at exploring factors that predispose women to IPV in the Vhembe district. The researcher applied a contextual study designed to solicit data from the participants in their natural environments

3.5.2 Study Population

According to Etikan and Bala (2017), a population in research can be defined as a group of people or a set of objects with similar characteristics unique to them. This study targeted the women who are victims of violence. In this study, the population included all survivors who were victims of intimate partner violence. Women aged 18-65 years who are victims of IPV and reported the case at the Thohoyandou Victim Empowerment Centre were the study subjects. There are about 792 women who are victims of intimate partner violence and are clients at the centre.

3.5.3 Sampling

For this study, a non-probability purposive sampling technique was used. Asiamah, Mensah & Oteng-Abayie (2017) claim that selecting participants for qualitative study requires careful consideration of the information they have to acquire rich data. Purposive sampling or

judgmental sampling uses researchers' knowledge about the population to select sample members.

3.5.3.2 Size of sample used in the qualitative phase

Unlike in the quantitative phase where the sample size was determined before sampling, in the qualitative phase, the sample size was determined during the data collection stage using data saturation (Blaikie, 2018). Some studies recommend that in a qualitative study, the sample size be determined during data collection at the saturation stage (Creswell & Plano Clark, 2017). Similarly, interviews with participants were conducted until no new ideas about the problem were said to the participants (Nevhutanda, 2019). The researcher anticipated interviewing 25 women and more if data saturation is not reached, the interviews continue until data saturation and the sample size was then determined.

Inclusion criteria for victims

- Women aged 18-65 years who are victims of IPV and reported the case
- Willingness to partake in the study
- Living in the Vhembe district

Exclusion criteria for participants

- Women below 18 years and above 65 years
- Women who were not willing to participate in the study because of their personal reasons
- Women who were staying outside the borders of the Vhembe district

3.5.4 Data collection instrument

The semi-structured in-depth interview guide was developed and was used to collect data from twenty-five victims of domestic violence. The main data gathering technique for qualitative research was interviewing a sample of participants (Paradis, O'Brien, Nimmon, Bandiera & Martimianakis, 2016). For the successful collection of qualitative data using interviews, there was a need to create and sustain a certain level of participants (Blaikie, 2018) In conducting the semi-structured in-depth interviews with victims of domestic violence, the researcher used open-ended guide questions. Follow-up probing questions were used to

collect the required data (Flick, 2017). According to Asiamah, Mensah & Oteng-Abayie (2017), semi-structured in-depth interviews allow the experiences, meanings, values and priorities of participants to emerge with minimal interference from the researcher. Semi-structured in-depth interviews allow the researcher to introduce a theme or topic and then let the interviewee develop his or her ideas while the researcher listened. These guides were administered in either English, Tshivenda or Xitsonga which are the main dominant languages in the district.

3.5.4.1 Pre-testing the interview guide

The researcher did pre-test the interview guide/schedule after construction to test the research participants' understanding of the main question, to check the kind of information that would be gathered, the processes and procedures of conducting the interviews and its duration. The researcher conducted this pre-test with a data collection tool which was administered to 10% of the total participants. This exercise allowed the researcher to review, improve and change the main question (if needs be) based on the outcomes of the pre-test. In addition, the pre-test assisted the researcher to test the interview guide, modify it and make estimates of the time. The researcher also utilized the pre-test of data collection tools as an opportunity to practice and refine the study design, data collection instruments and analysis plans.

3.5.4.2 Data collection procedure

The researcher did seek consent and arranged individual appointments a week before the actual date of the interviews with each participant. Permission to use the record of the interview by means of an audiotape was sought from individual participants. This was to ensure that under no circumstance the researcher loses any of the discussions. Data were collected until saturation is reached. The researcher organised a venue with no interruptions that did not distract interviews. The interviews collected biographical data from participants to provide further context and illumination to the findings. The researcher was assisted by trained research assistants to facilitate all the interviews and utilised several skills to get enough information from the participants. Probing was the first skill which was used by the researcher. Phrases such as “tell more about”, “please elaborate” and “that is interesting” were used. Additionally, clarification was also used during interviews, for instance, the researcher used sayings such as “Let’s see whether I understood you correctly, you said that ...”. Furthermore, a minimum verbal response such as “eeeh” or “yes” was used to allow the participants the room to elaborate more. Non-verbal cues were also made use of.

To elicit data from the respondents the researcher also made use of field notes and observations. Field notes are written accounts of what happens and transpire in the course of the interviews; what the researcher used, experienced or saw. After each interview, the researcher wrote field notes, and items such as personal feelings, reflections, key phrases, emotions and events that transpired. The non-verbal behaviour of the participants was captured utilizing observational notes. Furthermore, the researcher requested permission to audiotape each interview session from the respective participants. The recordings were used to maximise data collection to avoid losing information. Each interview session was conducted in the vernacular language of the participant.

3.5.4.3 Training of research assistants

The researcher recruited and trained two research assistants who assisted in collecting data throughout the study. The training was on the administration of the questionnaire and interview guide and how to conduct a pre-test of the two research instruments, as well as on ethical issues. Considering the scope or setting of the study, there is a need to recruit and train research assistants who are post-graduate students with health and social science backgrounds were recruited as research assistants. The training took place before data collection and it was done for two days. The research assistants were trained on the following aspects: on the first day and the second day the assistants were taught how to administer questions, how conduct interviews, use tape recorders, and assist with interview logistics.

3.5. Data analysis

Data were analysed using the Interpretative Phenomenological Analysis framework (Smith, 2009). The main aim of the analysis of data in this study is to understand the reasons why women are violently abused. The interviews were transcribed and transcripts notes were identified with proper identification code and grouped according to the category of the participants, for example, staff interviews were grouped. The analysis of all transcribed verbatim interviews was done through six phases described in detail below:

Step 1: Repeated reading- This was the initiation step in which reading and re-reading of data (interview transcripts) were done for the researcher to be familiar with the participants' stories (account). Repeated reading allowed for a model of the overall interview structure to develop and permitted the researcher to gain an understanding of how narratives can bind certain sections of an interview together (Smith, 2009).

Step 2: Initial noting - The second step is in which notes of worthwhile ideas from the participants' accounts about the phenomenon were made by the researcher. Here, the researcher examined semantic content and language used on an extremely exploratory level. The researcher maintained an open mind and noted anything within the transcript that was of interest. This process enabled the researcher to familiarise themselves with the transcript, and have a deep understanding of the stories. The researcher began to identify trends and the style in which participants expressed themselves, understood and thought about the problem. The aim here was to produce a comprehensive and detailed set of notes and comments on the data. Smith (2009) posits that exploratory comment requires the analysis of transcript to be able to interpret the content without bias. This means that the researcher must understand the "keywords, phrases or explanations" that the participants utter when recording (Smith, Flowers & Larkin, 2009). Such understandings play an important role in well-providing explanations of what is important to the participants who describe the world and experiences using different events, experiences and objects that mean a lot in their lives (Smith, Flowers & Larkin, 2009). The authors encourage researchers to be cautious as participants express meaning to experiences and feeling through a variety of ways including "descriptions, assumptions, sound bites, acronyms, idiosyncratic figures of speech, and emotional responses" (Smith, Flowers & Larkin, 2009:34). Important to the researcher should make notes in detail for everything said or done as well as highlighting objects consistently referred to. Another key element of noting in an exploratory way is concerned with language. The researcher focused on the reflection of the transcript as well as how the content and meaning are presented.

Step 3: 'Developing emergent themes'- This step involved the development of emergent themes which captured the connotation of the stories (accounts) of the participants. Smith, (2009) advises that researchers need to be cautious that the interview transcript remains important during data analysis but there was a need for becoming clearer by making meaningful and understandable exploratory comments as the data pool grows bigger and bigger. The researcher needs to keep track of new themes emerging from the data and familiarise themselves with the relationships of the subthemes being exposed (Smith, 2009). By analysing and exploring comments, the researcher can further identify new themes to focus on from different transcripts. The researcher was expected to remember what was learned from the process of developing themes.

Step 4: Searching for connection across emergent themes. This step consists of the researcher searching for connections across emergent themes. The researcher accomplished this through specific ways of looking for connections as well as patterns between connections.

- **Abstraction:** This is a basic form of identifying patterns between emergent themes and developing a sense of what is called a “super-ordinate theme” (Smith, 2009). The researcher developed a new name for the cluster by identifying patterns between emergent themes and developing a super-ordinate theme.
- **Subsumption:** this is an analytical process to abstraction but it operates where an emergent theme itself acquires a super-ordinate status as it helps bring together a series of related themes (Smith, 2009). Through this process, the researcher unified a series of related themes under one super-ordinate theme.
- **Polarisation:** This is the examination of transcripts for the operational relationships between emergent themes by focusing upon difference instead of similarity (Smith, 2009). Through this process, the researcher examined all transcripts for operational relationships between emergent themes. A focus was put on the differences among themes as opposed to the similarities among the themes.
- **Contextualisation:** This was a useful way of looking at the connections between emergent themes by identifying the contextual or narrative elements within the analysis (Smith, 2009). Through this process, the researcher looked at the connections between emergent themes and therefore was used to identify the contextual or narrative elements within the analysis.
- **Numeration:** This was the frequency with which a theme was supported. Numeration reflects the frequency with which emergent themes appear throughout the transcripts. If the interview style was particularly open-ended and unstructured, it makes sense to think of the frequency with which emergent themes appear as one indication of their relative importance and relevance to the participant (Smith, 2009). Through this process, the researcher identified themes that were of importance and relevance to the participants.
- **Function:** This was the examination of themes for their specific function within the transcripts. The negative aspects of self-transformation following diagnosis can be seen as serving to position the participant as a victim of circumstances (eliciting

sympathy and care from the listener), while positive themes relating to re-assertion of self can be seen as a means of the positioning [herself] as a survivor, or hero within the narrative (Smith, 2009). The researcher assessed the functions of themes to differentiate between the negative and positive ones to make appropriate assumptions and conclusions.

- **Bringing it together:** Organising themes in more than one way was creative and push the analysis to a higher level. Once the process of exploring patterns and connections has ceased and the analyst feels comfortable with the outcome, it is important to make notes about how this key stage of analysis was conducted (Smith, 2009). The researcher kept records of the analysis process and commentaries on the analytical work that was done. In addition, the researcher achieved this through a graphical representation of the structure of the emergent themes. The researcher then created a table of the emerging themes and subthemes.

Step 5: Developing a master table of themes containing super-ordinate themes, sub-themes, and quotes from interview transcripts. After completing and going through all the above-mentioned steps, the researcher then proceeded to make the main table to place themes. This table contained the main themes and sub-themes.

Step 6: Development of a single master table of themes from the master table of themes and individual interview transcripts. In this last step, the researcher developed a single master table. This master table is the summary of all the master tables of all the super-ordinate themes, sub-themes, quotes from individual interview transcripts and interview numbers, transcript numbers as well as page numbers on individual interview transcripts. This single master table reflected the findings of the study which were presented in the next chapter. Figure 3.2 depicts the data analysis steps followed.

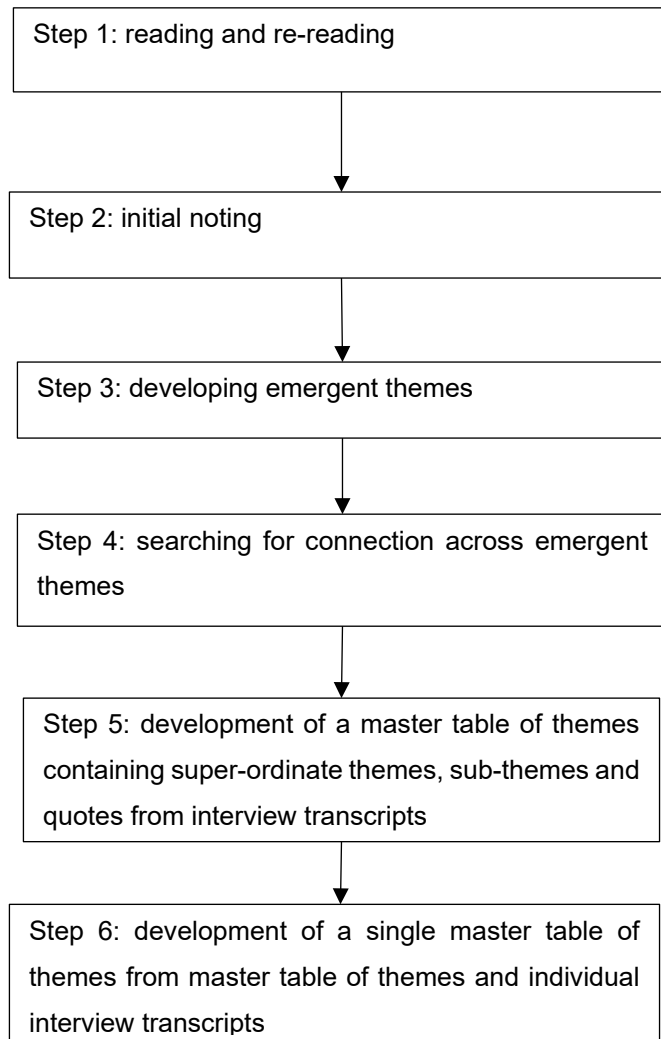


Figure 3.2: Data analysis steps followed

3.5.6 Trustworthiness and rigour of the study.

According to LoBiondo-Wood & Haber (2017), trustworthiness is a means of how the researcher's inquiry persuades his or her audiences and himself/herself that the findings of an enquiry are worth paying attention to or accounting for. The researcher ensured trustworthiness by observing and following the following notions of objectivity: credibility, transferability, dependability as well as conformability.

3.5.6.1 Credibility

Credibility refers to the ability of the researcher to accurately identify and properly describe the research problem (Nevhutanda, 2019; Yin 2003). According to Patton (2016:257) credibility refers to "the degree to which the findings of a study accurately report the actual

feelings, behaviours and awareness of participants towards a particular phenomenon”. This implies that credibility extends to the integrity of the data provided by research participants. In a study collecting qualitative data, credibility involves checking if the results of the study are believable from the participants’ perspective (Patton, 2015; Trochim, 2006). For this study, credibility was attained by ascertaining that the data collected tallied with what the participant said during the interview. After transcribing interviews, the participants were requested to verify their transcripts and possibly make corrections where possible. For the notes taken by the researcher, more care was put to make them tally with transcripts. The researcher also made a consultation with participants during debriefing. Participants were consulted for clarity during report writing to confirm certain statements.

3.5.6.2 Dependability

According to Trochim (2006), dependability refers to the ability of a research study to explain changing contexts within which the study takes place to produce stable data needed to answer research questions or to understand the problem further. Dependability seeks to ascertain that a study can be replicated to provide the same results. To cater for dependability, the researcher put much effort into clarity on how the research study was carried out as well as providing reasons for choosing research techniques and data collection tools used (Golafshani, 2003). This was achieved by following Yin’s (2003) and Trochim’s (2006) encouragement of taking the responsibility for explaining any adjustments occurring place in the settings of the study and how those new changes would influence the way the researcher has to undertake the study. This required the researcher to systematically gather data by using identified key information about IPV and its effects. Dependability was also catered for by utilising reliable data coding approaches and understandable explanations and meanings (LoBiondo-Wood & Haber 2017).

3.5.6.3 Transferability

Several authors regard transferability as a measure used to check how best the findings of the current study can be generalised to or used in different research in similar situations or settings that may be problematic (Creswell, 2004; 2006; Nunu, Makhado, Mabunda & Lebese, 2020). Transferability was enhanced in this study by systematically describing the research settings and key theories used in the study as recommended by Dooley (2002). According to Trochim (2006), the researcher or any interested individual who intends to use the results of a study in another context has to decide how meaningful and appropriate these could be for a study where there are to be used. In the context of the current study, transferability was

accounted for by the researcher who provided detailed descriptions of the research process, the key area to focus on as well as the study results and findings. The researcher was able to determine whether the findings were generalisable and made recommendations for the study.

3.5.6.3 Conformability.

Conformability can be viewed as the impartiality of the conclusions made by a study and these depend on what research participants' views instead the biased preconceived views of the researcher (Golafshani, 2003). or the degree other researchers or participants can conform to or collaborate on the findings of a research study (Trochim, 2006). According to Marshall & Rossmann (2006), the study needs to demonstrate with evidence that it meets the requirements of conformability and not what the researcher thinks should be the case. To achieve conformability, the researcher, tenaciously documented every essential step for scrutinising and authenticating the data collected from various participants and respondents (Trochim, 2006). This was done to enable the researcher to scrutinise the data collection and analysis methods as well as to check any possibilities of prejudice or misrepresentation made by the researcher (Golafshani, 2003; Yin, 2003). Ultimately, participants with an interest in the ongoing study were allowed to check the results during the validation stages of the developed strategies (Golafshani, 2003). All participants who took part in the interviews had an opportunity to access the data collected to confirm the credibility of the data.

3.6 Phase 2 Development and validation of strategies.

3.6.1 Development of the strategies

The strategies were developed from the findings of the research study. Further considerations were made on the available literature which was critically analysed before inputs from experts on IPV were solicited. Moreover, the development of the strategies was guided by the IMB, the theoretical framework used in this study. The strategies presented using three components of the IMB namely, Information, Motivation and Behaviour skills. The intuitive insights of the researcher played a key role in this study as they supplemented the findings, literature review, and experts. Eventually, the findings of the study were integrated into IBM during the strategy development stage.

3.6.2 Validation of the developed strategies

Validation of strategy aims at determining the feasibility, applicability, acceptability and sustainability of these strategies in attaining desired goals (Foundation, 2004). Key stakeholders needed to evaluate and develop strategies to ensure that they do not undermine or violate the values of different health system users. Strategy evaluation would follow two key stages. The first stage would involve the Delphi technique, whilst the second stage would involve the administration of a checklist to specific key stakeholders. The issues relating to the validation of the strategy are discussed below

3.6.2.1 Validation of strategies

Validation of strategies was aimed at determining the feasibility, applicability, acceptability and sustainability of these strategies in attaining desired goals. The first stage, as indicated under 3.6.2, involved the Delphi technique, meanwhile, the second stage involved the administration of a checklist for specific key stakeholders.

3.6.2.2 Expert Review

The Delphi technique is a systematic, interactive method that is used in forecasting the future regarding proposed methods, strategies and the likely impact they could have if they are implemented (Izaryk & Skarakis-Doyle, 2017). The objective of the method was to seek expert opinion on the developed strategies or implementation plans and forecast their likely impact in attaining set goals and objectives and their appropriateness (Njuangang, Liyanage & Akintoye, 2017). This method is suitable for guiding strategy development in this research. Between 5 to 20 experts specializing in gender-based violence were recruited.

3.6.3.3 Key Stakeholder Consultation

These included the Department of Social Development, Education, Health, Justice, Police representatives, health service providers, victim empowerment centres in the province, community leaders and academics. All key stakeholders were recruited using purposive sampling to ensure that the targeted categories of key stakeholders are all represented. A checklist was used to gather data on key stakeholders' opinions on the feasibility, accessibility and sustainability of the proposed strategy.

3.7 Ethical considerations

3.7.1 Permission to conduct a study

For quality assessment purposes, the researcher presented the proposal to the Department of Public Health and the School Higher Degrees Committee. After the approval of the proposal was approved by the University Higher Degrees Committee, the University of Venda Research Ethics Committee issued an ethical clearance for the study to commence data collection preparations. The researcher went on to get permission to collect data from the Vhembe Department of Justice, Vhembe Department of Social Development and Health and the management of the TVEP.

3.7.2 Confidentiality

Confidentiality is a commitment made by the researcher to keep all the information provided to participants safe and publicly reported in a manner that does not reveal who the identified sources are. The questionnaires, field notes and tape recorder during data collection are kept in a locked locker for five years for reference purposes where necessary and they are not be made available to people who are not part of the study. Confidentiality was maintained using a password that was only for the researcher's personal computer, where only the researcher knows the password. All other information was kept in a safe cupboard that only the researcher has the key to and had access to.

3.7.3 Informed consent.

The researcher provided an information letter which stated the study objectives, how the study would be conducted and study aims. Participants were informed that they would not be receiving any form of remuneration for participating in the study. The researcher indicated in the letter that participants could withdraw from the study without explaining anything to the researcher. If the study has foreseeable risk, participants were going to be informed of those risks, fortunately, there was none. If a person was willing to participate in the study, he/she gave a consent form in writing for them to sign to show that they want to participate in the study.

3.7.4 Voluntary participation.

The participants were indeed informed by the researcher that taking part in the study should be voluntary and can stop participating at any time if they wanted to do so. This information on the right to voluntary participation was made available to the participants during the recruitment as well as before the start of the interview sessions. Participants were further told they had a right to terminate the interview or participation whenever they felt uncomfortable with the questions or anything emanating from the study.

3.7.5 Right to privacy.

The participants were assured that the research report will not disclose any information about the participant's behaviour during the interview. No information will be made public unless written permission to disclose the information is given to the researcher by the participants. For that reason, the interviews were conducted at the participants' convenient places or settings to ensure the privacy and confidentiality of the information.

3.7.6 Right to Anonymity.

The participants were further informed that they had the right to choose if they wished to take part in this study or not. Those who volunteered to take part in this study were informed that they can withdraw at any point of the study without consequences of any nature and that they might also refuse to give an answer to any questions that they do not want to answer and still be able to remain in the study. However, respondents were asked to provide responses to all the questions for the study to be meaningful and also be able to yield reliable results that are valid. Participants were also informed that any information that was obtained about this study and that could be identified with them would remain confidential and were disclosed only with their permission or as required by law. This information was to be made available to the Department of Public Health of the University of Venda and the findings were likely to be presented at a selected conference and subsequently published without the identification of the participants. Any material that might have been identified by participants was not used in the study.

3.8 Conclusion.

This chapter aimed to provide a detailed explanation of the research methodology used in all the phases which included both phases namely the qualitative phase which is phase 1a and phase 1b. The plan of the study and the budget were outlined in a table in this chapter. Finally, the researcher discussed the most significant aspect of the research which is the ethical considerations that showed all the processes that the researcher followed until permission to conduct the study was granted. Therefore, Chapter 4 is dedicated to the analysis and interpretation of quantitative data which is phase 1(a) of the study.

CHAPTER 4

PRESENTATION AND INTERPRETATION OF QUANTITATIVE RESULTS

4.1 Introduction

The study aimed to develop strategies to empower women against IPV occurrences in the Vhembe district. Phase 1a was for the Quantitative phase with objectives stated as:

- To measure the level of general knowledge regarding intimate partner violence among IPV victims in the Vhembe district.
- To describe the victim's motivational attitude towards the acquired IPV information to act against any form of IPV behaviour in the Vhembe district.
- To assess the behavioural skills used by victims in dealing with any IPV occurrence.

The previous chapter provided a detailed research design and methodology that guided data collection and analysis for both Phases 1a and 1b. This chapter analyses and interprets quantitative results for the data collected in Phase 1(a) of the empirical study. Quantitative data analysis was accomplished with the assistance of the software package "Statistical Package for Social Sciences" (SPSS) Version 27. Subsequent sections are dedicated to the presentation and interpretations of the results.

4.2 Presentation of results and interpretation

The response rate was very high, with 685 of 792 (86,4%) respondents completing and returning the questionnaire to the researcher. Data were analysed by a statistician using SPSS 27. A simple descriptive analysis was followed in which results were presented as frequency tables and graphs. Basic correlational analysis and Chi-Square tests were used to check the investigated variables' dependency.

4.2.1 Section A: Demographic data.

Figure 4.1 summarises the socio-demographics of the participants. The findings show that most (30,7%, n=201) of the participants were living with their partners, but were not married, followed by (28,5%, n=195) of married participants, then (17,2%, n=118) of the participants who are separated from their abusive partners. About (16,2%, n=91) of the participants were

divorced, followed by (6,1%, n=42) of participants who were unmarried and not living with their partners. The least number of participants was (1,9%, n=9) widow respondents. Figure 4.1 summarises the respondents' marital statuses.

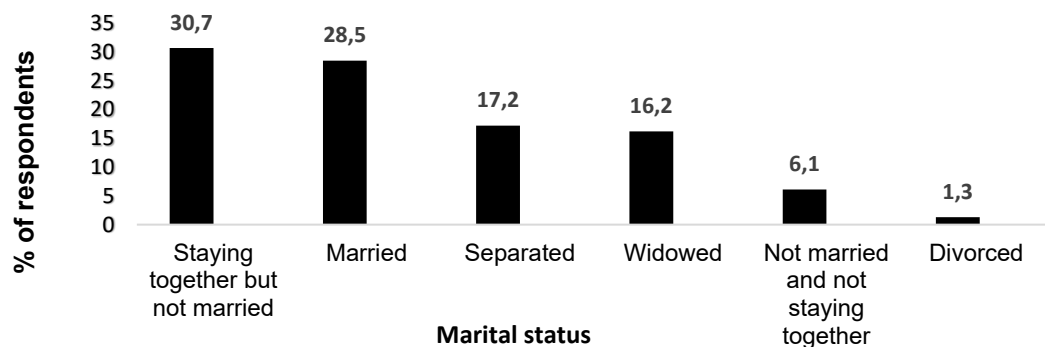


Figure 4.1: Marital status of the respondents.

The findings show that the majority (31.5%, n=216) of participants were between the ages of 20 and 29, followed by those aged 30 to 39 at 26.7% (n=183). On the other hand, participants above 50 years of age were few, e.g. 50-59 made 7.6% (n=52), whereas those above 60 years were only 4.4% (n= 30). Figure 4.2 shows the respondent's age.

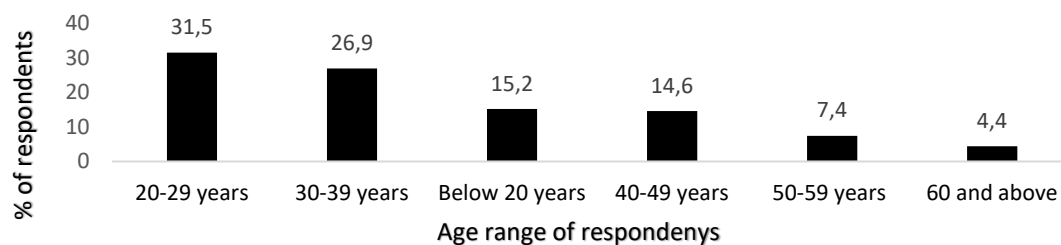


Figure 4.2: Age of respondents

The findings show that the majority (62.3%, n =427) of participants got married or became involved in a relationship between the ages of 20 and 29, followed by those who got married between 30 and 39 (19.4% n =133), and those between the ages of 40 and 49 (10.7% n= 73). Few participants (6.6% n=45) got married below the age of 20 years. Only 1% (n=7) got married between 50 and 59 years.

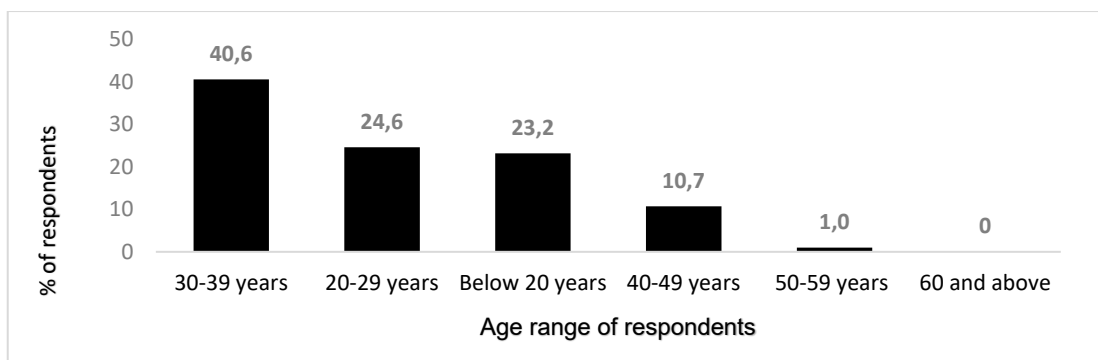


Figure 4.3: Age at marriage/relationship

Figure 4.4 shows the result of the participants' religious affiliation. The majority (45.5%, n =314) of the participants were of the African religion/tradition, followed by 44.7% (n=306) Christians. Few (9.5%, n=65) participants belonged to other religions.

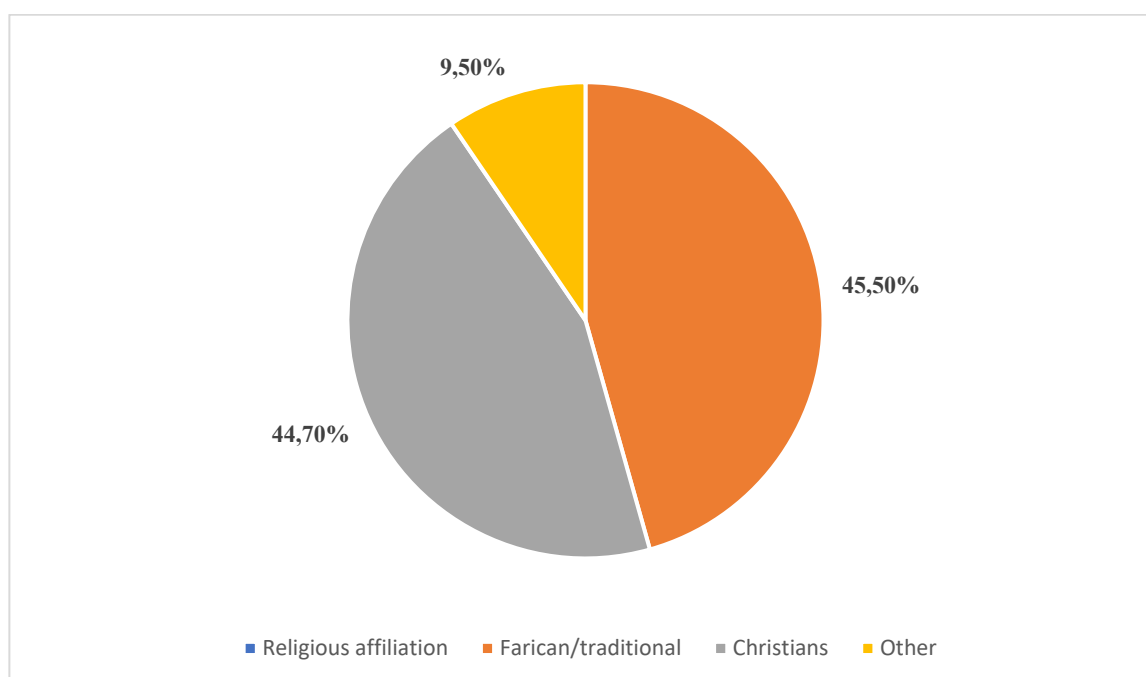


Figure 4.4: Religious affiliation

Table 4.1 presents the level of education and income of participants and their spouses. The results show that the majority (54,6%, n=374) attended school until the secondary level, followed by 24,5% (n=168) who only had a primary level of education. 18,2% (n=125) attended a tertiary institution. A few participants (2,6%, n=18), who left school, were illiterate. The majority (86,1 %, n=590) of the participants had children and only (13,9%, n=95) had no

children. Out of 590 respondents who reported having kids, the majority (24,1 %, n=142) were those with four kids (20,6 %, n=141), followed by participants with five kids and above (20,6%, n=141).

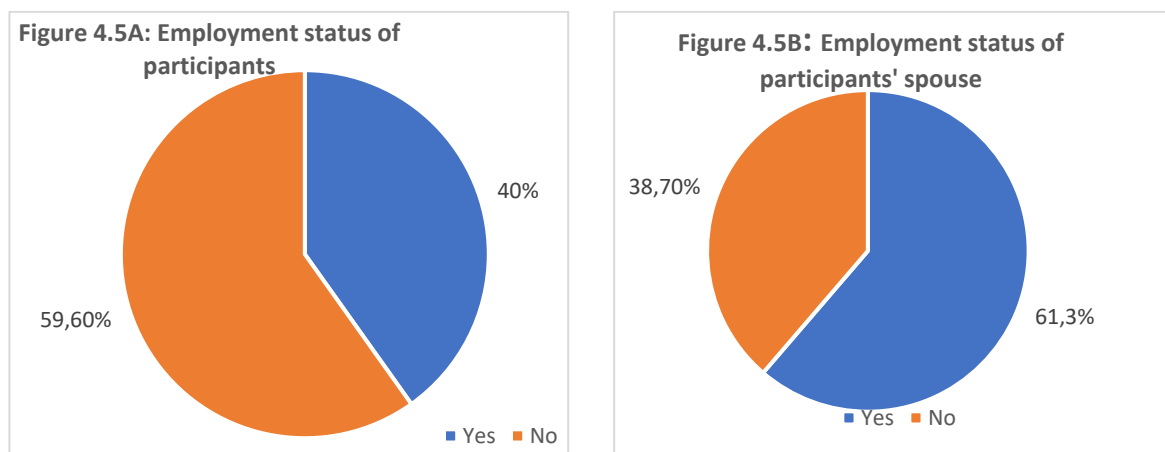
Table 4.1: Level of education and income of participants and their spouses.

Level of education:	Participants		Participants' spouses	
Item	%		%	
1. Illiterate	2.6	18	24.1	1 §65
2. Primary	24.5	168	37.4	256
3. Secondary	54.6	374	29.1	199
4. Tertiary	18.2	125	9.5	65
Level of income:	Participants		Participants' spouses	
Item	%		%	
1. Below R 3 500	23.5	161	25.5	175
2. R 3 501 – R 10 000	5.8	40	12.8	88
3. R 10 001 – R 20 000	3.5	24	10.5	72
4. R 20 001 – R 30 000	2.6	18	3.2	22
5. R 30 001 – R 40 000 and above	3.1	21	6.3	43
Total	38.5	264	61.3	420
6. Missing data/No income	61.5	421	38.7	38.7

Table 4.1 shows that the majority (37,4%, n=256) of the participants' spouses attended school until the secondary level, followed by 29,1% (n=199) with primary school education, and those who went to a tertiary institution were 24,1% (n=125). A few participants (1,1%, n=18), who left school, were illiterate. Out of the 420 participants whose partners were unemployed, the majority (25,5% n=175) were earning a salary below R 3 500, followed by 12,8% (n=88) who were earning between R 3 501 and R 10,000. 10,5% (n=72) were earning between R 10,001 and R 20,000. About 6,3% (n=43) of participants' partners were earning between R 30,001

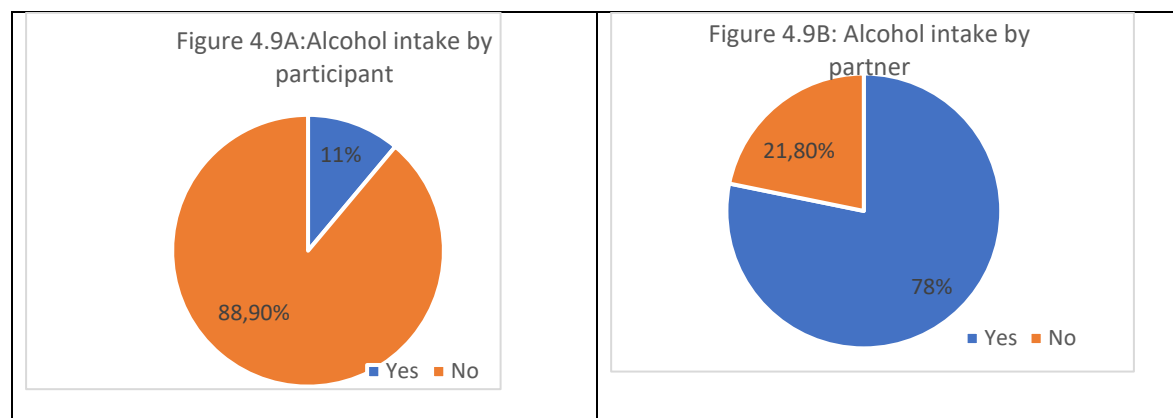
and R 40,000 and 10,5% (n=22) were earning between R 20,001 to R 30,000. A few of the participants' spouses (2,9% n=20) earned above R40, 0001.

Figure 4.5A shows that most participants (59,6%, n=408) were unemployed, and only 40.4% (n=277) were working. Figure 4.5B shows that the majority of participants (61,3% n=420) indicated that their partners were working, and 38,7% (n=265) of participants' partners were unemployed.



Figures 4.5A and 4.5B: Employment statuses of the participant and spouse

Figure 4.6A shows that the majority of the participants do not consume alcohol (88,9%, n=609), whereas only 11,1% of the victims consume alcohol. However, most participants indicated that their spouses or partners consumed alcohol. Figure 4.6B shows that most of the participants' spouses, 78.2% (n=536), consume alcohol and 21,8% (n=149) do not.



Figures 4.6A and 4.6B: Alcohol intake statuses

Of the 685 respondents, only 438 indicated the number of children in the second relationship, see Figure 4.7. The minority of respondents (13,9%; n = 95) did not conceive children in their second relationship, whereas 9,9% (n = 68) had one child. Close to (37%; n= 239) of the respondents had 2 to 3 children and less than (6%; n= 36) had more than 3 children.

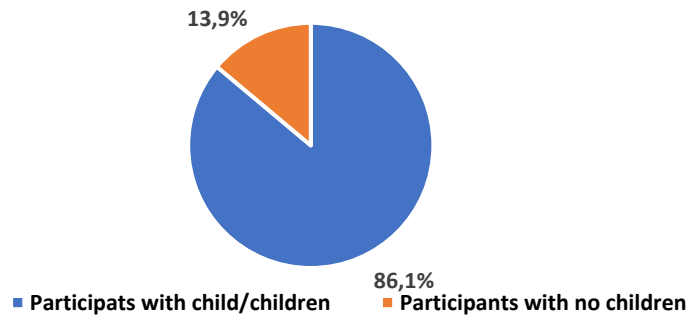


Figure 4.7: Participants with/with no child/children

Figure 4.8. shows the distribution of respondents by children from relationships.

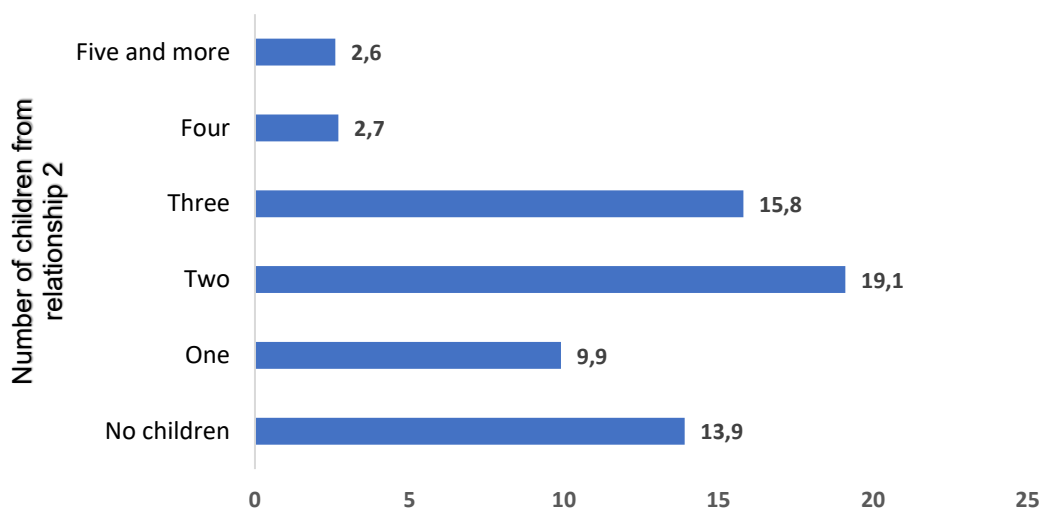


Figure 4.8: Children from the same relationship

The majority (55.2%, n=378) had children from their previous relationships, while the minority (44.8%, n=307) had no children from previous relationships. This included 95 participants who did not have children.

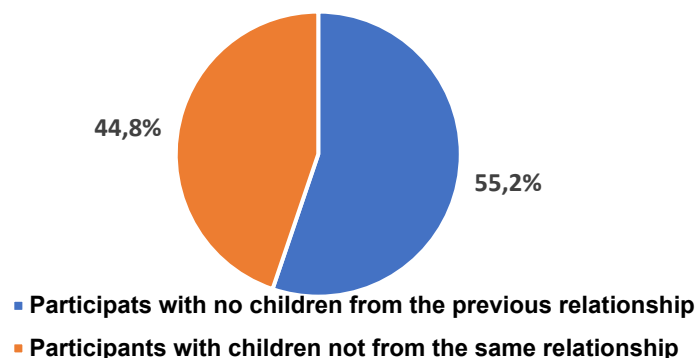


Figure 4.9: Number of children from the same and different relationships.

4.2.2 Section B: Accessing media and making decisions

Table 4.2 shows access to media and decision-making. The majority of participants (35,6%, n=244) watches television, followed by 24,5% (n=168) who listens to the radio. A few participants (18,7%, n=) who listen have access to both television and radio, followed by 21,5% (n=145) who do not listen to the radio or watch television. Many respondents (58,1%, n=398) do not have the final say in their health and decision-making autonomy, followed by 32,7% (n=224) who partially participated in the decision-making about their health. A few participants (9,2%, n= 63) have the final say and autonomy in decision-making concerning their health. Many of the respondents, 48,8% (n=334), do not have the final say on household purchases for daily needs, whereas about 32,7% (n=224) of the partially participate in their health. The minority (9.2%, n=) have the final say and full participation in their health.

Table 4.2: Access to media and decision-making

Item	Frequency	Per cent (%)
Access to media		
1. Watches TV	244	35.6
2. Listens to radio	168	24.5
3. All of the above	128	18.7
4. None of the above	145	21.2
TOTAL	685	100
Final say in decision-making about own health		
1. Full participation	63	9.2
2. Partial participation	224	32.7
3. Not at all	398	58.1

TOTAL	685	100
Final say on household purchases for daily needs		
1. Full participation	92	13.4
2. Partial participation	259	37.8
3. Not at all	334	48.8
TOTAL	685	100

4.2.3 Section C: Intimate partner violence knowledge.

Respondents were asked to indicate which types of behaviour between intimate partners could be described by the construct IPV. The researcher categorised participants' overall knowledge component using Blooms' cut-off point-scoring. The knowledge component was subdivided into four sections in which the participants had to choose between Yes/No responses, whereby "Yes" was regarded as a correct and "No" as an incorrect answer. (i) 5 questions about forms of IPV (1-2 =poor, 4 =average and 5 =high), (ii) 5 questions on effects of IPV (iii) (1-2 =poor, 3-4 =average and 5 =high), (iv) 11 questions on causes of IPV (1-4 =poor, 5-8 =average and 9-11=high), and (v) 35 questions on prevention and support of IPV (1-12 =poor, 13-25 =average and 26-35=high).

The researcher graded the knowledge component using Blooms' cut-off point-scoring. The knowledge component had 16 questions. Therefore, the score ranged from 0 to 16 and overlap the score of knowledge regarding IPV was defined as poor/insufficient knowledge, average and high/adequate. The results are shown in Table 4.3.

Table 4.3: Intimate partner violence knowledge.

Item: Component of the knowledge	Frequency	Per cent (%)
Being slapped or pushed by an intimate partner is a form of IPV		
Yes	587	85.7
No	98	14.3
Total	685	100
Being forced to have sexual intercourse by an intimate partner is a form of IPV.		
Yes	251	36.6
No	434	63.4
Total	685	100
Being scorned is a form of violence against women if committed by intimate partners		
Yes	481	70.2
No	204	29.8
Total	685	100
Being scared or intimidated on purpose by an intimate partner is considered intimate partner violence		
Yes	322	48.0
No	365	52.0
Total	685	100
Any conduct that consists of deprivation of work tools, assets or economic resources is considered to be IPV		
Yes	329	47.0
No	356	53.0
Total		

	685	100
Does IPV have effects on the economy		
Yes	214	31.2
No	471	68.8
Total	685	100
Does IPV have effects on family		
Yes	476	69.5
No	209	30.5
Total	685	100
Does IPV affect children		
Yes	181	26.4
No	504	73.6
Total	685	100
Does IPV affect society		
Yes	225	32.8
No	460	67.2
Total	685	100
Does IPV affect health		
Yes	641	93.6
No	44	6.4
Total	685	100

Table 4.3 shows that most participants (85,7%, n=587) knew that being slapped or pushed by an IP is a form of IPV, while few (14,3%, n=98) said they did not know that it is a form of IPV. Few (63,4%, n=251) participants did not know that being forced into sexual intercourse by an IP is a form of IPV, and the majority (70,2%, n=481) knew that being forced to have sexual intercourse by an IP is a form of IPV. The majority (85,7%, n=587) knew that being slapped or pushed by an IP is a form of IPV, whilst few (14,3%, n=98) did not know that it is a form of

IPV. Most respondents (70,2%, n=481) reported that being scorned is a form of IPV if committed by an IP, whilst a few (29,8%, n=204) did not know that it is a form of IPV. The majority of the participants (52,0%, n=356) did not know that being scared or intimidated on purpose by an IP is a form of IPV, whereas few (48,0%, n=329) knew. Most participants (53,0%, n=363) did not know that IPV affects assets or the economy, while few (47,3%, n=322) reported it as a form of IPV.

Which of the following factors do you think cause IPV?

The majority of the participants, 58,8%, showed that women depending on men for food, shelter and other material things are more likely to become victims of domestic violence, as opposed to 41,2% who responded no. 51,1% responded that men in employment were likely to be easily irritated and despondent, leading to domestic violence, and 49.9% did not see it as a factor. About 68.6% of the participants said a lack of resources increases the likelihood of domestic violence, as opposed to 31,4% who responded that it is not a factor that causes violence. The majority of women, 84,8%, confirmed that drug and alcohol abuse always led to unnecessary domestic violence, whereas 15,2% did not share the same view.

Table 4.4: Types and effects of IPV

Item: Types and effects of IPV	Frequency	Per cent (%)
Being slapped or pushed by an intimate partner is a form of IPV		
Yes	587	85.7
No	98	14.3
Total	685	100
Being forced to have sexual intercourse by an intimate partner is a form of IPV.		
Yes	251	36.6
No	434	63.4
Total	685	100

Item: Types and effects of IPV	Frequency	Per cent (%)
Being scorned is a form of violence against women if committed by intimate partners		
Yes	481	70.2
No	204	29.8
Total	685	100
Being scared or intimidated on purpose by an intimate partner is considered intimate partner violence		
Yes	322	47
No	365	53
Total	685	100
Any conduct that consists of deprivation of work tools, assets or economic resources is considered to be IPV		
Yes	329	48
No	356	52
Total	685	100
Does IPV have effects on the economy		
Yes	214	31.2
No	471	68.8
Total	685	100
Does IPV have effects on family		
Yes	476	69.5
No	209	30.5
Total	685	100

Item: Types and effects of IPV	Frequency	Per cent (%)
Does IPV have effects on children		
Yes	181	26.4
No	504	73.6
Total	685	100
Does IPV have effects on society		
Yes	225	32.8
No	460	67.2
Total	685	100
Does IPV have effects on health		
Yes	641	93.6
No	44	6.4
Total	685	100

Women who usually rely on men for food, shelter and other basic needs are more likely to be targeted by perpetrators of domestic violence. Many respondents, 87,3% (n=598), do not believe that boys who see their fathers behaving violently toward mothers have higher chances of violent behaviour when they become adults, although 15,7% (n=87) agreed that it was a factor. Furthermore, 52,1% (n=350) agreed that unemployed men were more likely to get easily frustrated and depressed, which led to domestic violence, and 48,9% (n=335) did not agree.

Most of the women, 68,6% (n=470), shared the idea that a shortage of basic resources, such as a house or money, increased the chances of domestic violence targeting women, whereas 31,4% (n=215) did not hold the same view. In addition, most of the women, 84,8%(n=581), agreed that drug and alcohol dependence leads to IPV, and only a few women disagreed.

Many participants, 52,1% (n=357), showed that a high level of women's education could not lead to domestic violence, and 47,9% (n=328) showed that it was a factor. Moreover, 73,3 % (n=502) of the participants showed that poor education among men always led to domestic violence, and only 26,7% (n=183) did not share the same view. Most women, 75,3% (n=516), did not believe that misinterpreting religious texts, in which men have the right to use domestic

violence to correct women, was the cause of domestic violence; only 24,7% (n=169) said it is a factor.

Many respondents, 81,5% (n=558), showed that a low education level among women was another cause of domestic violence in rural communities, and 18,5% (n=127) disagreed. Most of the respondents, 75,2% (n=508), showed that tolerance of domestic violence against women leads to its recurrence, and 25,8% (n=177) said no. About 61,3% (n=420) of the participants responded that existing disparities between men and women in rural communities and society did not result in domestic violence, and 38,7% (n=265) disagreed.

Availability of prevention and support services

Table 4.5 presents the results of available IPV services. The majority of the women (78,7%, n=539) knew that trying to avoid your partner was one of the available IPV prevention methods, and a few (21,3%, n=146) did not know. A few (45,8%, n=314) agreed that trying to avoid an argument with their partner was also available, and the majority (54,2%, n=371) of the participants did not know. A few women (23,2%, n=159) disagreed that staying away from their partners when distressed would help. The majority (55,5%, n=76,8) of the women knew that making their partner happy and acting more intimately toward them was a good recourse, while a few (44,5%, n=305) were unaware. The majority of the women (66%, n=452) did not know the availability of prevention and support services and a few (34%, n=233) did not know.

Table 4.5: Available IPV services

Item: Component of the knowledge	Frequency	Per cent (%)
Placating		
Tried to avoid him		
Yes	539	78.8
No	146	21.3
Total	685	100
“Tried to avoid an argument with him”		
Yes	314	76.8
No	371	23.2
Total	685	100

Item: Component of the knowledge	Frequency	Per cent (%)
“Staying away from him when he is on edge”		
Yes	526	76.8
No	159	23.2
Total	685	100
“Appeasing the husband and trying to act more intimate toward him”		
Yes	380	55.5
No	305	44.5
Total	685	100
“Tried to improve your behaviour towards him”		
Yes	233	380
No	452	305
Total	685	100
Resistance		
Fought back verbally		
Yes	463	67.7
No	222	32.4
Total	685	100
Refused to say what he said		
Yes	106	15.5
No	579	84.5
Total	685	100
Ended or tried to end the relationship		
Yes	348	50.8
No	337	49.2
Total	685	100
Used or threatened a weapon against him		
Yes	405	59.1
No	280	40.9
Total	685	100

Item: Component of the knowledge	Frequency	Per cent (%)
Left home to get away from him		
Yes	188	27.4
No	497	72.6
Total	685	100
Chose to sleep separately from him		
Yes	399	58.2
No	286	41.8
Total	685	100
Ended or tried to end the relationship		
Yes	610	89.1
No	75	10.9
Total	685	100

Resistance

Table 4.5 on available IPV services shows that few respondents (32,4%, n=222) did not know that fighting back verbally is one of the available strategies, and the majority (67,6%, n=463) knew. The majority of the respondents (84,5%,n=579) did not know that refusing to do what their spouses or boyfriends wanted was an available strategy. Few (49,2%, n=337) knew that ending or trying to end the relationship with their partner was also available, and most participants (50,8%, n=348) knew. Although a few women (49,2%, n=337) did not know that using or threatening their loved ones with a weapon is a strategy they can use, the majority (50,8%, n=348) knew. Most women (72,6%, n=497) said leaving home and getting away from their partners is the strategy one can use, but a few (27,4%, n=188) did not consider this a strategy. Most women (58,2%,n=399) regard sleeping separately as a strategy available, while the rest (42.8%, n=286) do not consider it an option.

Safety Planning

Table 4.6 shows the knowledge component: safety planning and legal route

Table 4.6: Knowledge component: safety planning and legal route

Item: Safety planning and legal route	Frequency	Per cent (%)
Safety planning		
Put a knife, gun or another weapon nearby		
Yes	185	27
No	500	73
Total	685	100
Hid the car or house keys		
Yes	14	2
No	671	98
Total	685	100
Kept money and other valuables hidden		
Yes	398	58.1
No	287	41.9
Total	685	100
Developed code, so others know there is danger		
Yes	55	8
No	630	92
Total	685	100
Worked out an escape plan		
Yes	422	61.6
No	263	38.4
Total	685	100
Removed or hid the weapon		
Yes	413	60.3

Item: Safety planning and legal route	Frequency	Per cent (%)
No	272	39.7
Total	685	100
Kept important phone numbers to get help		
Yes	54	7.9
No	631	92.1
Total	685	100
Changed lock or improved security		
Yes	332	48.5
No	353	51.5
Total	685	100
Kept important papers hidden		
Yes	389	56.8
No	296	43.2
Total	685	100
Kept extra supply of necessities		
Yes	14	2.0
No	671	98.0
Total	685	100
Legal		
Filed a petition for a protection order		
Yes	217	31.7
No	468	68.3
Total	685	100

Item: Safety planning and legal route	Frequency	Per cent (%)
Sought help from legal aid		
Yes	155	31.7
No	530	68.3
Total	685	685
Filed or tried to file criminal charges		
Yes	278	40.6
No	407	59.4
Total	685	100
Called the police or called someone else to intervene		
Yes	363	53
No	322	47
Total	685	100
Filed for divorce in court		
Yes	111	16.2
No	574	83.8
Total	685	100

The table on the knowledge component regarding safety planning and legal route presents that the majority (73%, n=500) did not know that putting a knife, gun, or another weapon nearby was a safety planning method, and few (27%, n=185) knew them as tools to be used. Few (2%, n=14) knew that hiding car or house keys could be used as a preventative measure, whereas the majority (98%, n=671) putting a knife, gun, or another weapon nearby is a safety planning method, and few (27%, n=185) knew them as tools to be used. Few (2%, n=14) knew that hiding car or house keys could be used as a preventative measure, whereas the majority (98%, n=671) did not. A few respondents (41,9%, n=287) did not know that keeping money and other valuables hidden from the IP could be a preventative measure, whereas the majority (58,1%, n=398) knew. The majority (92,0%, n=630) knew that developing a code so others

knew when they were in danger could be a preventative measure, whereas a few (8%, n=55) did not.

Although a few respondents (38,4%, n=263) did not know that working out an escape plan could be a preventative measure, the majority (61,6%, n=422) knew. A few participants (51,5%, n=332) did not know that changing locks or improving security could be used as a preventative measure, whereas the majority (48,5%, n=332) did. Some respondents (43,2%, n=296) did not know that keeping important papers hidden from their IP could be used as a preventative measure, but the majority (56,8%, n=389) knew. Even though most participants (98,0%, n=671) did not know that keeping extra necessities could be used as a preventative measure, a few (2,0%, n=14) knew. The majority (92,1%, n=631) of participants did not know that keeping important phone numbers that they could access during the violence to get help could be used as one of the preventative measures; however, a few (7,9%, n=54) did.

Legal

Table 4.6 on the knowledge component presents the results on knowledge regarding legal routes available to assist female victims. The results show that the majority (68,3%, n=217) and a few (31,7%, n=31,7) said they did not know. Few (22%, n=155) did not know they could seek help from legal aid, while the majority (77,4%, n=22,6) did. Few women (40,6%, n=278) did have knowledge and majority (59,6%, n=407). The majority (53,0%, n=363) knew they could call the police or ask someone else to intervene, while 47% (n=322) did now. Most (83,8%, n=574) did not know that filing a divorce assists in ending IPV, and only a few participants (16,2 %, n=111) knew that it could assist.

Formal services available

Table 4.7 on the knowledge component on formal and informal services available shows that the majority (81,9%, n=561) of participants did not know that trying to stay with the family was an option, whereas only 21% (n=144) were aware. Few (11,1%, n=76) disagreed with making sure other people were around, while 88,9% (n=609) knew this was an available option. Most participants (80%, n =548) agreed that they did not know that sending the children to stay with a friend/relative was an option, and only 20% (n=137) said yes. A few participants (11,1%, n=76) agreed they did not want people to be around them, whereas the majority (88,9%, n=609) disagreed. The majority (80%, n=548) of participants preferred not to send their children away hence 20%(n=137) of the women.

Table 4.7: Formal and Informal services available

Item: Knowledge component: Formal and Informal Services	Frequency	Per cent (%)
Item: Formal		
Tried to get help from employer/co-worker		
Yes	124	18.1
No	561	81.9
Total	685	100
Stayed at a shelter		
Yes	37	5.4
No	648	96.6
Total	685	100
Tried to get help from clergy, pastor, etc.		
Yes	642	93.7
No	43	6.3
Total	204	29.8
	685	100
Tried to get him counselling for violence		
Yes	211	30.8
No	474	69.2
Total	685	100
Made an effort to have him get assistance for alcohol or/and substance abuse		
Yes	24	3.5
No	661	96.5
Total	685	100
Called a mental health counsellor for self		

Yes	110	16.1
No	575	83.9
Total	685	100
Talked to officers of the domestic violence program		
Yes	667	97.4
No	18	2.6
Total	685	100
Talked to a doctor or nurse about abuse		
Yes	559	81.6
No	126	18.4
Total	685	100
Item: Informal	Frequency	Per cent (%)
Asking his parents, sisters and brothers for help and support		
Yes		
No	315	46.0
Total	370	54.0
	684	100
Sent children to stay with friend/relative		
Yes	137	20
No	548	80
Total	685	100
Made sure there were people around them.		
Yes	76	11.1
No	609	88.9
Total	685	100

Stayed with family or friends		
Yes	144	21
No	541	79
Total	685	100

Informal network

Table 4.7 shows that most participants (79%, n=541) knew to stay with family, whereas only 21% (n=144) did not. Few (11,1%, n=76) disagreed with making sure other people were around, whilst 88,9% (n=609) agreed. The majority (80%, n =548) of the participants agreed that they did not know that sending the children to stay with a friend/relative was an option, and only 20% (n=137) were aware. A few participants (11,1%, n=76) agreed they did not want people around them, whereas the majority (88,9%, n=609) disagreed. The majority (80%, n=548) preferred not to send their children away; 20% (n=137) of the women agreed. More than half (54%, n=370) preferred to ask his parents, sisters and brothers for help, and 46% (n=315) preferred not to talk to them about the abuse.

Table 4.8 shows that the majority (82,3%, n=564) of participants' knowledge level regarding the term IPV is fair or average, followed by poor knowledge with 15% (n=103). Few (2,6%, n=18) have very little knowledge regarding IPV. The majority (90,4%, n=619) of participants' knowledge level summary regarding the effects is fair or average, followed by 5,1% (n=35) of those with poor knowledge. Few (4,5%, n=31) had low knowledge regarding the effects of IPV. Few (3,9%, n=27) participants' knowledge levels regarding the causes of IPV were fair or average, followed by 9,9%(n=68) of participants with poor knowledge. The majority (86,1%, n=590) of participants' knowledge regarding the causes of IPV was high. A few (7,2%, n=49) of the participants' knowledge level regarding the prevention and support services of IPV was high or adequate, followed by 12,3%(n=84) participants with fair or average knowledge. The majority (80,6%, n=552) of participants' knowledge regarding the prevention and support services of IPV was very poor.

Table 4.8 Knowledge level summary regarding IPV

Knowledge:	Scoring, Frequencies and Percentages on the knowledge level							
	Poor		Fair		High/ Average		Total	
Item no.	n	%	n	%	n	%	n	%
1. Knowledge level summary regarding the term IPV	103	15	564	82.4	18	2.6	685	100
2. Knowledge level summary regarding the effects of IPV	35	5.1	619	90.4	81	4.5	685	100
3. Knowledge level summary regarding the causes of IPV	68	9.9	27	3.9	590	86.1	685	100
4. Knowledge level summary regarding the prevention and support services of IPV	552	80.6	84	12.3	49	7.2	685	100

4.2 Section D: Motivation

Placating

Table 4.9 shows that few (48,5%, n=332) agreed that women should try to prevent the behaviour of perpetrators by using placating, and the majority of participants (51,5%, n=353) disagreed.

Resistance

Table 4.9 shows that the majority (86,4%, n=592) agreed that women should try to prevent the behaviour of perpetrators by using some forms of resistance, and few participants(13,6%, n=93) disagreed.

Safety Planning

Table 4.9 shows that the majority (86%, n=589) agreed that women should try to prevent the behaviour of perpetrators by safe planning, and only a few participants (14%, n=96) disagreed.

Legal

Table 4.9 shows that the majority (69,8%, n=478) disagreed that women should try to prevent the behaviour of perpetrators by using the legal route, and few participants (30,2%, n=207) agreed.

Table 4.9: Motivation

Motivation	Scoring, Frequencies and Percentages on the knowledge level				
	Agree		Disagree		Total
Item no.	N	%	N	%	No
1. To what extent do you agree that women should try to prevent this behaviour by Placating	332	48.5	353	51.6	685
2. To what extent do you agree that women should try to prevent this behaviour by Resistance	592	86.4	93	13.6	685
3. To what extent do you agree that women should try to prevent this behaviour through Safe Planning	589	86	96	14	685
4. To what extent do you agree that women should try to prevent this behaviour by Legal Route	207	30.2	478	69.8	685
5. To what extent do you agree that women should try to prevent this behaviour by Formal Network	632	92.3	53	7.7	685
6. To what extent do you agree that women should try to prevent this behaviour by Informal Network	65	9.5	620	90.5	685

Formal Network

Table 4.7 shows that the majority (92,3%, n=632) agreed that women should try to prevent the behaviour of perpetrators by using formal networks, and a few (7,7%, n=53) participants agreed.

Informal Network

Table 4.7 shows that few (9,5%, n=633) agreed that women should try to prevent the behaviour of perpetrators by using informal networks, and the majority of participants (90,5%, n=685) disagreed.

4.2.4. Section E: Behavioural skills/strategy

Figure 4.10 summarises strategies to deal with IPV. The findings show that the majority of the participants (31,5%, n=216) agreed to have used resistance as a strategy to deal with IPV occurrences, followed by 22,6%(n=156) of those who used formal networks, and those who used placating were 9,6%(n=66). A few (3,6%, n=25) agreed that women could use safety planning as a strategy to deal with IPV occurrences, followed by 8,9%(n=61) of those who used the legal route. The results show that 5,0%(n=34) of participants agreed to have women use safety planning as a strategy to deal with IPV occurrences. Only 18,5% (n=127) showed that they had not used any strategy to deal with IPV (these are the women whose cases were referred to centres dealing with IPV by family or friends, neighbours and family as well as community members).

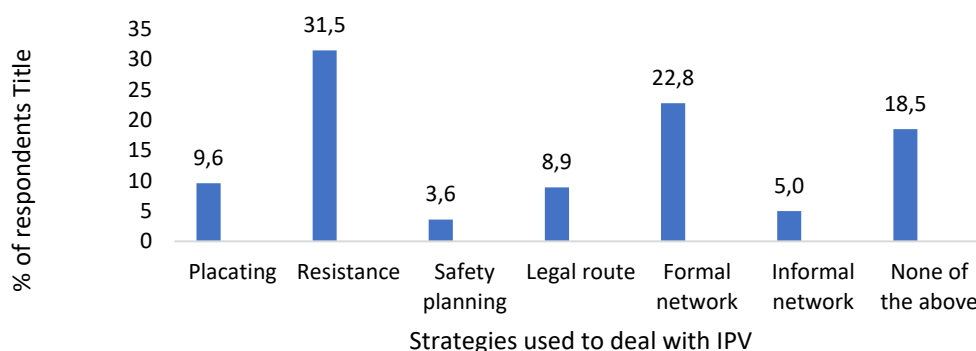


Figure 4.10: Strategies to deal with IPV

4.3 Chi-Square results

A Chi-Square test of independence was conducted for the religious affiliation of respondents and six motivation variables for women to take a particular action to prevent violent behaviour.

Results are shown in Tables 4.10 to 4.19. Table 4.10 shows the results for the Chi-Square test for the dependence of the use of placating as a strategy to prevent violence based on religious affiliations.

Table 4.10: Dependence of the extent to which women agree to try to prevent IPV by Placating

		To what extent do you agree that women should try to prevent this behaviour by Placating?				Total	Chi-Square	df	p-value	
		Strongly Agree	Agree	Disagree	Strongly Disagree					
Age of Respondents	Below 20 years	Observed Count	104	0	0	104	597.833	15	0,000	
		Expected Count	28,4	22,0	6,1	47,4				104,0
	20-29 years	Observed Count	31	109	0	76				216
		Expected Count	59,1	45,8	12,6	98,5				216,0
	30-39 years	Observed Count	24	36	36	87				183
		Expected Count	50,0	38,8	10,7	83,5				183,0
	40-49 years	Observed Count	28	0	4	68				100
		Expected Count	27,3	21,2	5,8	45,6				100,0
	50-59 years	Observed Count	0	0	0	51				51
		Expected Count	13,9	10,8	3,0	23,3				51,0
	60 years and above	Observed Count	0	0	0	30				30
		Expected Count	8,2	6,4	1,8	13,7				30,0
	Total	Observed Count	187	145	40	312				684
		Expected Count	187,0	145,0	40,0	312,0				684,0

The tendency to prevent violent behaviour by placating and the age of respondents were significantly associated, as indicated by the X^2 (597.833^a df = 15; N= 685; p =0.01). Women under 40 were more likely to agree strongly to prevent IPV by placating or being passive.

These results show that younger women were more likely to accept the abusive behaviour of intimate partners.

Table 4.11: Dependence between the age of marriage and the extent respondents agreed that women should try to prevent IPV behaviour by Resistance

			To what extent do you agree that women should try to prevent this behaviour by Resistance?				Total	Chi-Square	df	p-value
			Strongly Agree	Agree	Disagree	Strongly Disagree				
Age of marriage	Below 20 years	Count	45	0	0	0	45	225.833	12	0,001
		Expected Count	33,7	5,2	3,2	2,9	45,0			
	20-29 years	Count	310	79	23	15	427			
		Expected Count	319,8	49,2	30,5	27,4	427,0			
	30-39 years	Count	112	0	18	3	133			
		Expected Count	99,6	15,3	9,5	8,5	133,0			
	40-49 years	Count	46	0	8	19	73			
		Expected Count	54,7	8,4	5,2	4,7	73,0			
	50-59 years	Count	0	0	0	7	7			
		Expected Count	5,2	0,8	0,5	0,4	7,0			
	Total	Count	513	79	49	44	685			
		Expected Count	513,0	79,0	49,0	44,0	685,0			

The results in Table 4.11 confirm that a significant dependence existed between the age at which a woman was married and the extent of using resistance to prevent IPV behaviour X^2 (225.833; df = 12; N =685; p= 0.001). Women married between the age of 20 and 39 were more likely to resist than those above that age.

Table 4.12: Dependence on the extent women should try to prevent IPV behaviour by resistance and marital status

		To what extent do you agree that women should try to prevent this behaviour by Resistance?					Total	Chi-Square	df	p-value
		Strongly Agree	Agree	Disagree	Strongly Disagree					
Marital Status	Married	Count	172	23	0	0	195	454.535	15	0,001
		Expected Count	146,0	22,5	13,9	12,5	195,0			
	Widowed	Count	9	0	0	0	9			
		Expected Count	6,7	1,0	0,6	0,6	9,0			
	Divorced	Count	37	0	49	25	111			
		Expected Count	83,1	12,8	7,9	7,1	111,0			
	Separated	Count	99	0	0	19	118			
		Expected Count	88,4	13,6	8,4	7,6	118,0			
	Staying together but not married	Count	154	56	0	0	210			
		Expected Count	157,3	24,2	15,0	13,5	210,0			
	Not married and not staying together	Count	42	0	0	0	42			
		Expected Count	31,5	4,8	3,0	2,7	42,0			
	Total	Count	513	79	49	44	685			
		Expected Count	513,0	79,0	49,0	44,0	685,0			

The tendency to prevent violent behaviour by resistance was significantly associated with the marital status of respondents X^2 (454.535; df = 15; N = 685; p = 0.001), Table 4.12. Married and cohabiting respondents were more likely to strongly agree with using resistance as a form of curbing violent behaviour by their partners.

Table 4.13: Association of marital status and the extent of the prevention of IPV behaviour by safe planning

		To what extent do you agree that women should try to prevent this behaviour through Safe Planning?					Total	Chi-Square	df	p-value
		Strongly Agree	Agree	Disagree	Strongly Disagree					
Marital Status	Married	Count	0	0	0	195	195	257,346	15	0,001
		Expected Count	20,5	6,8	18,8	148,9	195,0			
	Widowed	Count	0	0	0	9	9			
		Expected Count	0,9	0,3	0,9	6,9	9,0			
	Divorced	Count	20	0	43	48	111			
		Expected Count	11,7	3,9	10,7	84,7	111,0			
	Separated	Count	17	0	7	94	118			
		Expected Count	12,4	4,1	11,4	90,1	118,0			
	Staying together but not married	Count	35	24	16	135	210			
		Expected Count	22,1	7,4	20,2	160,3	210,0			
	Not married and not staying together	Count	0	0	0	42	42			
		Expected Count	4,4	1,5	4,0	32,1	42,0			
	Total	Count	72	24	66	523	685			
		Expected Count	72,0	24,0	66,0	523,0	685,0			

The results in Table 4.13 (X^2 (257.346a; df = 15; N =685; p = 0.001) show a significant dependence between marital status and the use of safe planning to prevent violent behaviour of intimate partners. Married women were more likely to strongly disagree that safe planning effectively solved the violent behaviour of intimate partners. Table 4.14 shows the results for the Chi-Square test for the dependence of the use of placating as a strategy to prevent violence based on religious affiliations.

Table 4.14: Chi-Square results for religious affiliation and the extent to which women can prevent violent behaviour by placating

			To what extent do you agree that women should try to prevent this behaviour by Placating?				Total	Chi-Square	df	p-value
			Strongly Agree	Agree	Disagree	Strongly Disagree				
Religion Affiliation of the Respondents	Christianity	Observed Count	163	11	0	132	306	359.706 ^a	6	0.000
		Expected Count	83.5	64.8	17.9	139.8	306			
	African Religion/Traditional	Observed Count	24	134	40	116	314			
		Expected Count	85.7	66.5	18.3	143.5	314			
	Other	Observed Count	0	0	0	65	65			
		Expected Count	17.7	13.8	3.8	29.7	65			
	Total	Observed Count	187	145	40	313	685			
		Expected Count	187	145	40	313	685			

The results on Table 4.14 show a significant dependence of the extent to which women can prevent violence by placating on the religious affiliation of the respondents, ($X^2 = 359.706$; $df = 6$; $N = 685$; $p = 0.000$). Christianity was more likely to influence women to prevent violent behaviour by placating the partner than respondents of traditional and other religious affiliations. This implies that religion plays an important role in preventing violent behaviour when using placating methods. The dependence of preventing violence by resistance on religious affiliation was tested using Chi-square analysis, see Table 4.15.

Table 4.15: Dependence of resistance to prevent violent behaviour based on the religious affiliation of respondents

		To what extent do you agree that women should try to prevent this behaviour by Resistance?					Total	Chi-Square	df	p-value
		Strongly Agree	Agree	Disagree	Strongly Disagree					
Religion Affiliation of the Respondents	Christianity	Observed Count	227	79	0	0	306	401.689 ^a	6	0.000
		Expected Count	229.2	35.3	21.9	19.7	306			
	African Religion/ Traditional	Observed Count	255	0	49	10	314			
		Expected Count	235.2	36.2	22.5	20.2	314			
	Other	Observed Count	31	0	0	34	65			
		Expected Count	48.7	7.5	4.6	4.2	65			
	Total	Observed Count	513	79	49	44	685			
		Expected Count	513	79	49	44	685			

The tendency to prevent violent behaviour by resistance and religious affiliation were significantly associated, as indicated by the X^2 (401.689; df = 6; N = 685; p = 0.00). Christian respondents were more likely to strongly agree with using a form of resistance to curb violent behaviour by their partners. According to these results, it is possible to prevent the violent behaviour of a partner of a particular religion using resistance.

The association between using safe planning to prevent violent behaviour and religious affiliation was investigated using the Chi-Square test of independence. The results are illustrated in Table 4.16. The results reveal an insignificant association between the two variables investigated with X^2 (55.646a; df = 6; N = 685; p = 0.060). This means that the use

of safe planning to reduce or prevent violent behaviour of partners was independent of the respondents' religious affiliation. Respondents of all religious affiliations were more likely to strongly disagree with the use of safe planning when dealing with any form of violent behaviour. This could mean that other factors could prevent safe planning when solving violent behaviour-

Table 4.16: Dependence of safe planning strategy to prevent violent behaviour based on the religious affiliation of respondents

		To what extent do you agree that women should try to prevent this behaviour by safe planning?						Total	Chi-Square	df	p-value
		Strongly Agree	Agree	Disagree	Strongly Disagree						
Religion Affiliation of the Respondents	Christianity	Observed Count	35	24	23	224	306	55.646 ^a	6	0.060	
		Expected Count	32.2	10.7	29.5	233.6	306				
	African Religion/Traditional	Observed Count	37	0	43	234	314				
		Expected Count	33	11	30.3	239.7	314				
	Other	Observed Count	0	0	0	65	65				
		Expected Count	6.8	2.3	6.3	49.6	65				
	Total	Observed Count	72	24	66	523	685				
		Expected Count	72	24	66	523	685				

Table 4.17 presents the Chi-Square results of the dependence of the use of legal routes on the religious affiliation of respondents.

Table 4.17: Dependence of legal route to prevent violent behaviour based on the religious affiliation of respondents

			To what extent do you agree that women should try to prevent this behaviour by a Legal Route?				Total	Chi-Square	df	p-value
			Strongly Agree	Agree	Disagree	Strongly Disagree				
Religion Affiliation of the Respondents	Christianity	Observed Count	79	106	56	65	306	315.861 ^a	6	0.000
		Expected Count	45.1	47.4	155.5	58.1	306			
	African Religion/Traditional	Observed Count	22	0	227	65	314			
		Expected Count	46.3	48.6	159.5	59.6	314			
	Other	Observed Count	0	0	65	0	65			
		Expected Count	9.6	10.1	33	12.3	65			
	Total	Observed Count	101	106	348	130	685			
		Expected Count	101	106	348	130	685			

The X^2 (315.861a; df = 6; N =685; p = 0.000) results reveal a significant association between the use of legal route and religious affiliation of respondents. This shows that the decision to use the legal route as a solution to violent behaviour was influenced by the different religions of the affected women. Christian respondents were more inclined to take a legal route than other religions.

Formal Networks play an important role in preventing violent behaviour between partners. The dependence of this strategy on religious affiliation was investigated using the Chi-Square test of independence, see Table 4.18.

Table 4.18: Dependence of formal network strategy to prevent violence based on the religious affiliation of respondents

		To what extent do you agree that women should try to prevent this behaviour by using a Formal Network?					Total	Chi-Square	df	p-value
		Strongly Agree	Agree	Disagree	Strongly Disagree					
Religion Affiliation of the Respondents	Christianity	Observed Count	248	11	21	26	306	63.035 ^a	6	0.000
		Expected Count	277.4	4.9	9.4	14.3	306			
	African Religion/ Traditional	Observed Count	308	0	0	6	314			
		Expected Count	284.7	5	9.6	14.7	314			
	Other	Observed Count	65	0	0	0	65			
		Expected Count	58.9	1	2	3	65			
	Total	Observed Count	621	11	21	32	685			
		Expected Count	621	11	21	32	685			

The X^2 (63.035^a; df = 6; N =685; p = 0.000) results reveal a significant association between the use of formal networks and the religious affiliation of respondents. Unlike in the previous situations, respondents in the African religion and those in other religious affiliations were more likely to strongly agree to use the formal network strategy to solve violent behaviour.

Lastly, it was important to determine the dependence of informal network strategy on preventing violence on respondents' religious affiliation, see Table 4.19.

Table 4.19: Dependence of informal network strategy based on the religious affiliation of respondents

		To what extent do you agree that women should try to prevent this behaviour by using an Informal Network?					Total	Chi-Square	df	p-value
		Strongly Agree	Agree	Disagree	Strongly Disagree					
Religion Affiliation of the Respondents	Christianity	Observed Count	0	15	75	216	306	343.516 ^a	6	0.000
		Expected Count	20.1	8.9	63	214	306			
	African Religion/Traditional	Observed Count	45	0	6	263	314			
		Expected Count	20.6	9.2	64.6	219.6	314			
	Other	Observed Count	0	5	60	0	65			
		Expected Count	4.3	1.9	13.4	45.5	65			
	Total	Observed Count	45	20	141	479	685			
		Expected Count	45	20	141	479	685			

A significant association exists between the use of informal network strategy to prevent violence and the religious affiliation of respondents, as indicated by the X^2 (343.516a df = 6; N = 685; p = 0.000). More respondents of the African Religious Affiliation were likely to strongly agree with using an informal network to prevent violent behaviour than Christians and respondents of other religions. The finding was that the strategies used by women to prevent violent behaviour were significantly associated with their religious affiliations.

4.4. Conclusion

This chapter presented a detailed data analysis and interpretation of the results using simple descriptive and inference statistics, namely Chi-square and Spearman Correlation. The findings shows that women had knowledge on IPV knowledge which include types, causes,

effects as well as availability of prevention and support services. With gaps in the IPV strategies still needing to be addressed by first-hand experiences from IPV victims, qualitative data was gathered using the methods already described in Chapter 3. The next chapter presents findings and discussions of Phase 1b, the qualitative phase of the study in which Phenomenological analysis was applied to qualitative data.

CHAPTER 5

PRESENTATION AND INTERPRETATION OF QUALITATIVE RESULTS

5.1. Introduction

The previous chapter presented quantitative data analysis and interpretation. This chapter presents findings and discussions from the qualitative phase of the study. Phenomenological analysis was applied to qualitative data, and the findings are presented as themes and subthemes, see Table 5.1. The remainder of the chapter is organised as follows: summary of findings presented as themes and subthemes, interpretation of findings, and conclusion of the chapter.

5.2. Summary of findings

The findings from the qualitative phase are presented as six themes and their subthemes in Table 5.1.

Table 5.1: Themes and subthemes from qualitative data

Theme	Subthemes
Theme 1: Forms of IPV experienced by women	1.1 Physical abuses such as beating and shoving 1.2. Verbal abuse and swearing 1.3. Emotional abuse and deprivation 1.4. Intimidation & death threats by IPV partners 1.5. Sexual abuse when victims are forced to have sex
Theme 2: Common causes of IPV	2.1. Mistrust & infidelity issues occur for both Ips 2.2. Low self-esteem & jealous 2.3. Alcohol & drug abuse 2.4. Disagreement on misuses of money & cultural beliefs 2.5. Bad influence by relatives & friends 2.6. Despises wife and attire 2.7. Different cultural beliefs 2.8. Disagreement about sexual intimacy positions

Theme 3: Effects of IPV among women	<ul style="list-style-type: none"> 3.1. Fear 3.2. Emotional stress and trauma 3.3. Bodily harm
Theme 4: Common strategies used to address IPV	<ul style="list-style-type: none"> 4.1. Reporting to relevant structures 4.2. Living with the problem 4.3. Police case or protection order 4.4. Counselling and debriefing 4.5. Leaving abusive men
Theme 5: Challenges posed by strategies used to address IPV	<ul style="list-style-type: none"> 5.1. Ineffective law systems 5.2. Fear of being bitten & forced submission 5.3. Fear of raising children alone 5.4. Difficult behavioural change for men 5.5. Ineffective law systems
Theme 6: Suggested strategies for coping with IPV	<ul style="list-style-type: none"> 6.1. Standing up against violent men 6.2. Economic empowerment of women 6.3. Teach men to love partners 6.4. Protection Order 6.5. Involving men in care work 6.7. Encouraging men to stop alcohol and drug abuse 6.8. Encourage men to be open with their feelings

5.3. Them 1: Forms of IPV experienced by women

Four major subthemes depicted in figure 5.1 were typical forms of IPV that most participants in this study prevalently experienced. Figure 5.2 shows the occurrence of each IPV among the data collected. Each IPV is discussed as a subtheme supported by extracts from the interview transcripts.

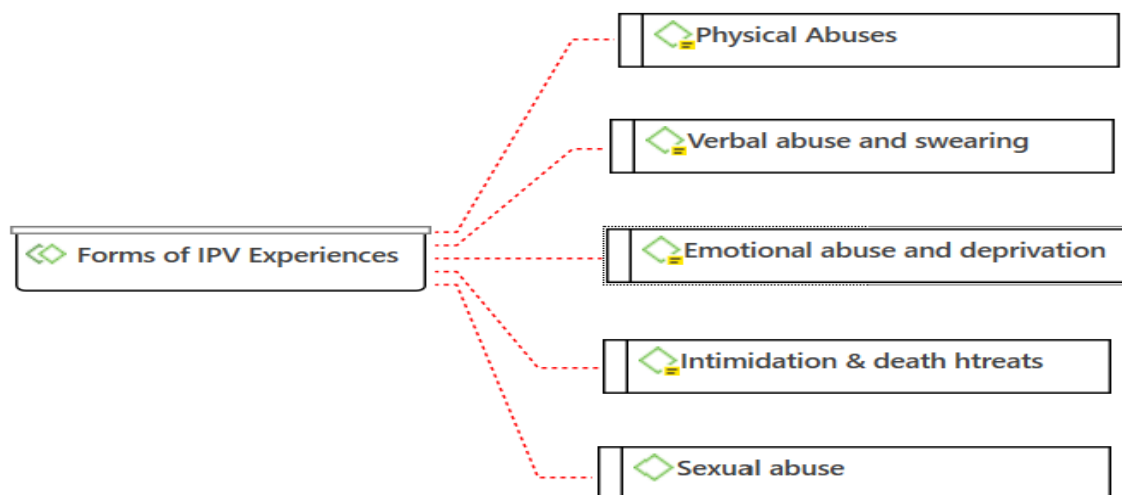


Figure 5.1: Prevalent IPV experienced by the participant

Name	Grounded
Physical Abuses~	14
Verbal abuse and swearing~	10
Emotional abuse and deprivation~	6
Intimidation & death threats~	4
Sexual abuse	2

Figure 5.2: An elaborate of IPV experienced by women

5.3.1 Subtheme 1.1: Physical Abuses

There seemed to be a consensus among participants that physical abuse by intimate partners was the most prevalent of all forms of IPV. Attestations by Participants 3, 4, 5, 6 and 7 revealed that beating was the most widely experienced physical abuse used by intimate partners. Participant 3 attested that her body's organs were malfunctioning due to physical violence. The citation demonstrates this assertion.

“He would beat me and beat the kids, I have scars all over the body my left hand is not working well because 5 years ago he twisted my arm, and the bone was broken. Again, my other eye does not see properly, he injured me when he was beating me in Nelspruit and was admitted, and he intimidated me not to tell the doctors at the military hospital.” [Participant 3].

Similarly, Participant 4 expressed physical violence in the form of beating and attempted burning, *“He always beat me and want to burn my genital parts because of his suspicion that was dating another man”*.

The utterances by Participant 5 confirm that physical violence against women occurred unabated and was extreme.

“I was severely beaten by my husband. I was taken to the hospital while unconscious. He continually abuses me by beating and swearing at me saying I am too dark, as well as taking my money.” [Participant 5]

Some of the physical abuse takes place in front of children, as indicated in Participant 6’s confession:

“... he started to fight me and the kids when I asked him he further grabbed me by the neck and beat me again in front of my kids and that woman... his concubine.. no one bothered to save me from that beat.”

This assertion shows that IPV perpetrators disregard the rights of children and their partners and use whatever means to harm women physically. In her attestation, Participant 7 expresses having experienced physical violence and the cruelty of her partner:

“He would beat me with an iron rod, he takes steel hanger and straighten it and beat me, burn me with the cigarette on the thighs.”

Besides beating women, some men turn their violent behaviour toward objects in the vicinity as a way to vent anger. Participant 1 indicated that her intimate partner was constantly in a rage whenever he did not get what he wanted.

“My partner always breaks properties in the house when it has started to be angry. No one can stop him once he starts throwing tantrums, ... he grabs whatever object is close to him and breaks it.

Participant 3 was concerned that her partner locked her out while he was sleeping with another woman at the same time.

“He used to lock the house and I and will be outside with the kids and ask help from the neighbours. This happened whenever he was angry or had another woman in the room.”

According to Participant 15, her IP tended to bang doors, shove her and her children, break beer bottles or even drive at high speeds when in rage.

“This happened so many times, that my husband easily gets angry. You will see this by when he bangs doors on houses and cars... he drives like crazy when angry. I am afraid that one day will get into an accident. He can keep quiet, and you notice it by breaking of beer bottles.”

The foregone narrations show that physical violence, especially beating women, is a common practice perpetuated by IPs.

5.3.2. Subtheme 1.2: Verbal Abuse and intimidation

The abuse of women goes beyond physical beating and shoving to verbal abuse and intimidation. Assertions from Participants 2, 3, 5, 8 and 15 allude to verbal abuse in which IPs tried to subdue women and make them submissive. Participant 2 said,

“He makes embarrassing comments about me or makes me feel inferior in front of other people. He likes to make a lot of verbal abuse when physical abuse fails. Recently, he made false accusations about my past that I forced him into marrying me, I margin saying this in front of his friends. Quite embarrassing for a person of my status.”

Some verbal abuse and intimidation occur in shops when altercations take place between the partners. A good case is exemplified by this assertion,

“When we are in the shop, he will leave me in the shop with the basket and say he won't pay, threatens me saying I should leave our home and must return to my family.. he forces and yells at me and the kids... he says he is a soldier and can kill because no police dare arrest him. He even threatens to kill me and the kids before killing myself. He calls me names he says I am (tititi, sometimes swita). I don't even know the meaning of those names.”

To make matters worse, some IPs say bad things about their partners, harming the relationship. Extracts by Participants 5, 8, 9 and 15 show that intimate partners verbally abuse and intimidate women.

“He talks bad things about me at home saying I am lazy, and I cannot cook, bad in bed, I like gossiping and causing fights among family members and relatives promote.”, [Participant 5]

“One day he overheard me talking to some union leaders about my work matters and he became furious and started calling me by names.” [Participant 8].

“Another day he overheard me talking to some club leaders about our club trip and he became furious and started calling me by names, slut, super bitch”, [Participant 9].

“He always abuses me verbally. I remember on 16 February 2019 he came home drunk around 19:00, started swearing at me with abusive words, insulting me and my late mother, and accusing her of our inability to conceive another child... He always calls me names ... tells me to leave his parent’s home and look for the domestic worker is a job from houses of other educated women because I am a non-fundi, meaning that I’m not educated”, [Participant 15]

These verbal abuses and intimidation by IPs seem to be of concern to women and have adverse effects on their relationships or married lives. Women are in constant fear of violent and abusive IPs. Detailed discussions of the effects of IPV are provided in subsequent sections of this chapter.

5.3.3. Subtheme 1.3: Emotional abuse and deprivation

Emotional abuse and deprivation of women from normal social life appeared to be a profound IPV practice, as reported by several participants of this study. Selected attestations from some participants confirm that violent male partners emotionally abused their female partners on many occasions. Participant 3 had this to say about deprivation:

“He never allows me to apply for a job. If I take the maintenance money and buy some stock for me to sell he says no, his wife does not work if you start going to sell or going to work you are out of this house and this marriage.”

This assertion clearly shows that violent men deprived women of the right to work or engage in activities that would empower women. This is a form of emotional abuse in which a woman is always stressed due to unnecessary constraints put on them by violent partners. Furthermore, *Participant 4* says that,

“If I go to his workplace and his bosses are saying or talking in English he says no one should interpret it for me. If I visit his workplace, he embarrasses

me in front of his colleagues by saying sinister things about my character. He enjoys seeing me stressed.”

Emotional abuse is also stressed by *Participant 9*, who says,

“He emotionally abuses me. Emotional abuse is not easily understood by other people. He doesn’t beat me. He abuses me emotionally and I left the church and started drinking alcohol and the church did not understand me.”

Women who were verbally abused and mistreated, beaten or humiliated in public suffered a lot of emotional abuse, a cause of stress in their daily lives.

Some women are emotionally abused and deprived of money because they cannot bear children. An example is shown by *Participant 11*, who says,

“He emotionally abuses me and does not allow me to use the money I earn he says he wants me not to claim anything when he leaves because I am barren, I am infertile.”

5.3.4. Subtheme 1.4: Intimidation and death threats

Intimidation and death threats have been identified as some of the IPV's that women continuously experience. Participants' utterances confirm that women in different forms of relations were subjected to intimidation and death threats by violent IPs. Extracts from attestation by *Participants 1, 3, 5 and 6* illustrate the assertion.

“Since I asked him why he withdrew money from my account without my permission, he has been intimidating me with death threats. He has changed so much. I am afraid that he may kill me one day.” [Participant 1].

“I have stopped sleeping in the same room with him from the time he threatened to kill me if I told his relatives about how he mistreated me. I think he is serious about killing me if I argue with him.” [Participant 3].

“My spouse threatened to send people to kill me if I continued asking him about money and his infidelity. He usually comes home and goes away without saying anything to me unless he wants to pick a fight with me. I am always scared, and I want to leave him. We depend on grant money, but he misuses that money.” [Participant 5],

“My husband is an SANDF soldier who thinks that he is above the law, police cannot do anything to him. Because of this, he likes and enjoys threatening me, he wants me to be afraid of him. He threatens with serious consequences, the death of me and my family if I disobey him. Whenever we argue about small things, he reminds that to remember who he is and what he can do to me and my miserable family.” [Participant 6].

These four extracts demonstrate women's feelings towards the violent nature of their IPs. Women facing IPV are always in constant fear of being murdered by their partners. Women live under fear of torture and death threats from IPs supposed to provide protection.

5.3.5. Subtheme 1.5: Sexual abuse

Sexual abuse is abuse that women suffer. Only three participants explicitly referred to sexual abuse by their IPs. Sexual abuse was in the form of forced sexual intimacy after IP was without foreplay (rape) (Participant 4), using positions that women found uncomfortable (Participant 6), and having sex without a condom for promiscuous IPs (Participant 14). The four extracts affirm the assertions,

“I do not enjoy sex with him he does it with no foreplay as if he is someone who is raping or afraid that he will get caught.” [Participant 4].

“I am always uncomfortable when having unprotected sex with my husband because he at times has STI from his prostitutes. I am afraid of contracting this disease. I tell him to put on a condom, but he refuses. This puts my life in danger every time we have sex.” [Participant 6]

“One day he called me to the bedroom, and he wanted sex and I said no and he forced and sleep with me”, [Participant 9]

“My partner wants us to use positions I am not comfortable with; I feel pain during intercourse. At times, he wants to penetrate my anus, something I am not used to. When I told him in the morning, he said that’s how we are going to have sex because he does not enjoy the normal way anymore referring to the vagina.” [Participant 14]

It is evident from these assertions that IPs sexually abuse women by forcing them into sexual intercourse without consent. This type of IPV behaviour can harm women concerning sex.

Participant 9's assertions show a deep-rooted problem in men having sex against women's will.

5.4. Theme 2: Common causes of IPV

Analysis of data reveals eight common causes of IPV, illustrated in Figures 5.3 and Figure 5.4.

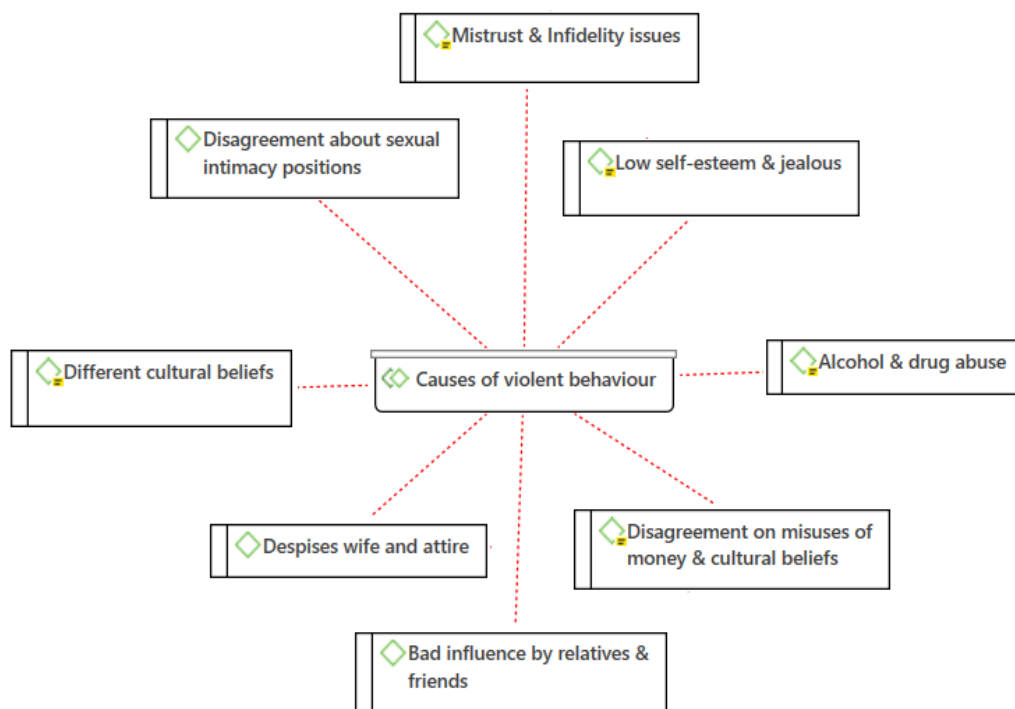


Figure 5.3: Common causes of IPV

Name	Grounded	
◇ Mistrust & Infidelity issues~	<div style="width: 80%;"></div>	8
◇ Low self-esteem & jealous~	<div style="width: 70%;"></div>	7
◇ Alcohol & drug abuse~	<div style="width: 70%;"></div>	7
◇ Disagreement on misuses of money & cultural beliefs~	<div style="width: 50%;"></div>	5
◇ Bad influence by relatives & friends	<div style="width: 40%;"></div>	4
◇ Despises wife and attire	<div style="width: 20%;"></div>	2
◇ Different cultural beliefs~	<div style="width: 20%;"></div>	2
◇ Disagreement about sexual intimacy positions	<div style="width: 20%;"></div>	2

Figure 5.4: Details of IPV causes

Figure 5.4 shows that mistrust and infidelity issues, low self-esteem and abuse of alcohol are the most prevalent causes of IPV. Each of the causes of IPV is examined as a subtheme in a separate subsection.

5.4.1. Subtheme 2.1: Mistrust between partners due to infidelity

Mistrust was the most cited cause of IPV in which the participants expressed that they always had problems with their IPs whom they suspected of cheating or had caught them cheating. Similarly, their IPs also suspected their female partners of cheating. Generally, arguments in resolving these suspicions led to violence with men IPs either beating or verbally abusing females. The following attestations confirm that mistrust between IPs was a major concern.

“My husband has got a suspicion that I might be having an affair and am cheating because that is how he is living ever since we celebrated our 10 years of marriage, he likes women too much both young and old.” [Participant 4]

This issue of extramarital affairs as a source of violence is also expressed by Participant 5, who indicated that her in-laws told her that her husband had an extramarital affair with another woman in the vicinity.

“The cause of our problems is my husband’s extramarital affair he is involved with another married woman... that is what my in-laws told me. One of the in-laws encouraging my husband to do that.” [Participant 5].

At times husbands become unreasonable and bring their friends and girlfriends, which makes spouses uncomfortable, leading to disputes, as observed by Participant 11.

“I have a problem with my husband. He would sometimes bring his girlfriends and his friends with their girlfriends to the house when I was at work or when I am at home during the weekends and month-end.” [Participant 11]

Participant 13 said her husband *“always falsely accuses me of cheating and being unfaithful”*. Furthermore, this has been going on for a long time. The two no longer trust each other, and the husband hauls a lot of verbal and physical abuse.

“As it is, I am experiencing a lot of insults and at times, he does not want to sleep with me as a punishment. He spends most of his time with his relatives who also scorn me. I am not having any affair, but he has so many girl friends around this place.” [Participant 13].

Sexual dysfunction is another cause of IPV in which the husband experiences such a problem and believes that his wife is having an affair with other men. One participant said,

“The other cause might be he has sexual dysfunction and I told him about it and he started fighting me that who did I sleep with, who is the best performer sexually. He also tells me he is sterile, infertile and he cannot have children and I should tell him who the father of my child is. I was told there is secondary infertility and he doesn’t know. I have not given up and I still believe one day I will get pregnant.” [Participant 15].

These assertions show that mistrust between partners can be caused by unsubstantiated suspicions and a lack of communication between the partners. Accusations and counter-accusations play a negative role, especially where relatives take sides with the transgressor. It is evident from the assertion by Participant 15 that the husband deliberately finds many excuses to abuse the woman without providing medical evidence to prove infertility.

5.4.2. Subtheme 2.2: Low self-esteem and jealousy

According to attestations in this study, most male partners felt insecure with their partners due to several reasons, such as jealousy, inferiority complex, and low self-esteem.

“The contributing factors for me being abused is because of inferior complex, my intimate partner becomes violent and more jealous when I receive a phone call and when I buy myself clothes, he feels jealous that other men will see and appreciate me.” [Participant 1]

This is alluded to by Participant 3, who says that,

“When we are travelling together with my husband and if someone greets me or if we are in a public transport, especially a male person, he looks at me scornfully and verbally abuses me at home about the incidence.”

Participant 3’s attestation is supported by Participant 13, who purports that he *“doesn’t even want to see me laughing or talking to males because he feels so jealous about it.”*

Participant 9 observes that her husband does not tolerate her way of dressing.

“He does not want me to wear shorts or miniskirts and trousers because other men will see the legs and love me. When I wear jeans he swears at me and he tells other ladies at the club the day we were having a baby shower.”

The extract from Participant 2 reveals that low self-esteem is another cause of IPV being experienced by female partners.

“I have seen that my husband has a problem when I do things better than him, he feels dejected and put off, and he complains about my pride because I think am better than him. He becomes aversive and ready to shove me or shout at me. I think my success hurts him so much.”

Participants 8 and 12 indicated to have been subjects of humiliation by their husbands after being promoted at work, indicating low self-esteem.

“My husband gets angry every time I am promoted at work. He will ask why I am the only one being promoted to a supervisor, he accuses me of having an affair with my boss at my workplace. He becomes violent and at times pushes me violently against the wall.” [Participant 8]

“He always tells me that all women being promoted at work were promiscuous because they are in love with those men who promote them. He does not even listen to me but wants me to remain unpromoted for many years. He feels threatened by my promotion.” [Participant 12]

The few cited attestations show that low self-esteem and jealousy among male partners are factors contributing to IPV in the study unit.

5.4.3. Subtheme 2.3: Alcohol and drug abuse

The third major cause of IPV was found to be Alcohol and drug abuse. Participants felt that their male partners exhibited violent behaviour mostly when under the influence of alcohol and drugs. Participants 6, 7, 10 and 15 attestations confirm that partners consuming alcohol and drugs had a high propensity to be violent.

“My husband is very violent when he comes home drunk and under the influence of weed (dagga). My husband is involved in, excessive intake of alcohol and drug. He uses abusive language. If asks me questions, I keep quiet, if I answer he gets infuriated and wants to punch me. But when he is sober, he talks sense. I think unemployment is another factor.” [Respondent 6]

Similarly, Participant 7 says,

“He drinks and abuses alcohol and he is a heavy dagga smoker. When he’s drunk he wants to make a provocative joke and gets very angry if I and my children keep quiet. At times he wants to talk too close to me with that smell of beer and dagga. It’s irritating ...”.

According to Participant 10, her partner always returns home drunk and does not tolerate anyone questioning him about being drunk.

“For my husband, the weekend is all about drinking throughout. At times he dropped home by friends the following morning very drunk and aggressive, insulting everyone, and playing the music very loud to the dislike of our neighbours. When I try to calm him, he shouts at me or even shoves me out of the house.”

“The guy is always drunk, and bed wets each time he comes home extremely drunk. He is very thin and has a very low appetite for food, and has a very low libido, or let me say the libido is non-existent. At some point, I even suspected that he might be cheating and comes home already satisfied from somewhere.” [Participant 15]

It is clear from the attestations show that abuse of alcohol and drugs is a major cause of IPV among the participants of this study. After getting drunk, the male partners become unreasonably violent and mistreat their female partners. It seems that alcohol and drugs make the male partners irresponsible as family heads, and they resort to violence to cover for their inadequacies.

5.4.4. Subtheme 2.4: Disagreement on money use

A considerable number of participants have expressed that IPV can be due to disagreements on money issues and cultural beliefs. According to Participant 3, the *“shortage of money in the house due to misuse”* by her husband always leads to heated arguments that can end up in fights. Participant 5 echoes the same sentiments by saying,

“Lack of resources and money at home because he misuses the money that he gets by going to the inyangas for reasons known to him. When I ask him, he tells me to shut up and mind my business or face his full anger.”

Participant 6 was concerned with money being withdrawn from her account by her husband, who refused to be accountable.

"I called the bank when I saw the money that was deducted from the bank. At 06h30, the money was withdrawn from the ATM and msg came to the phone; R3000.00 was withdrawn two times and again on the 15th of October. My husband refused and threatened me. He even asked me what I will do if he took the money, after all, I am his wife and what was wrong in misusing his wife's money." [Participant 6]

"We quarrel a lot because of the shortage of money in the house, which he misuses. He always reminds me that he is the one who labours and earns the money, if I wanted to control him, then I should go and work for my own money." [Participant 7]

The issue of money seems to be very sensitive and divisive among partners. These disagreements are fuelled by a lack of trust among partners and differences in cultural and religious beliefs.

Lastly, the study found that cultural beliefs were the cause of IPV in certain instances where money issues surfaced. Money was involved in an attempt to force women to follow men's beliefs. The citations show examples of the interrelationships.

"They are practising beliefs that I do not believe in, they are forcing him to force me to follow that belief. They believe in dead people because he is the one who is working and has money." [Participant 3]

"My in-laws think to support my husband because they think unemployed women should follow everything their husband does. They want me to perform rituals because I depend on their son for money and food." [Participant 11]

These attestations show how cultural beliefs and disagreements on using money can lead to IPV. Male partners seem to misuse money on the pretext of cultural beliefs, which infringe on the rights of their wives. These factors are interrelated with the influence of relatives and friends explored in the following subsection.

5.4.5. Subtheme 2.5: Bad influence from relatives and friends

Four participants attested that IPV they suffered was due to the negative influence of relatives and friends of their husbands or partners.

Participant 3 alleges that sisters-in-law can negatively influence their married brothers, whom they tend to depend on for financial and material support before marriage and after divorcing.

“His sister unmarried sister controls my husband more than the married one at and she hates me and she hates my children because he wants all his brother's money. She thinks that I am not entitled to the money but her only.”

The same views are expressed by Participants 6, 7 and 14, who have suffered more or less the same fate at the hands of their IPs' friends or relatives.

“My husband's friends influence him to go out with other women because I failed to give more children. When I tell his parents, they are not concerned, instead tell me to give him more children”, [Participant 6].

“At first, I used to ignore my husband's friends until I overheard them talking to him about fixing giving money to his former girlfriend whom he had a child. I have realised that these friends were a bad influence. One of my sisters-in-law is also involved.” [Participant 7].

“I found his elder sister who was drinking with his friends, and then she started insulting me, but I kept quiet because I did not want to cause a scene.” [Participant 14]

Certainly, in-laws, relatives and friends can cause rifts between partners, worsening if poorly managed. From these citations, the female partners managed the potentially disastrous situation but were let down by male partners under the negative influence of relatives and friends. It was evident from the citations that some women played an essential but negative role in destroying existing relationships.

5.4.6. Subtheme 2.6: Despises wife and attire

There was evidence from the narratives of a handful of participants that they suffer from IPV because their husbands despise them. Participants 6, 11 and 13 testified that their husbands seriously despised them due to a lack of formal education or their chosen attire. The cited extracts reveal that women are subjected to IPV because of their partners' hate.

Participant 6 has this to say:

“... swears at me that I'm shapeless and that I'm lighter in complexion but ugly and cannot even cook nice food. He also tells me that clothes do not fit shapeless structure”.

Participant 11 faced a similar fate,

“He always says I am not beautiful like his late wife, and he does not like the wife who wears trousers and does not wear doek on the head.”

The two extracts show the extent to which male partners deride their females based on their character and attire. Such comments dehumanise women and may lead to emotional and psychological problems.

Finally, Participant 13 indicated that she suffers much humiliation from her husband, especially when they go out shopping.

“I always feel insulted and humiliated by my husband who compares me to other women when shopping or walking, even when another young pass by. He always regrets for marrying me because I did not complete matric. Every time we argue, he will remind me of my failure to complete high and I know nothing about anything. This hurts me. Makes me feel so bad.”

There is evidence from the attestations that women being despised by their partners feel abused and suffer IPV, which needs to be addressed.

5.4.7. Subtheme 2.7: Different cultural beliefs

Cultural beliefs are a cause of IPV in this study. Participants attested that they are forced to abide by the cultural beliefs of their partners, whether married or not. Men tend to impose their cultural beliefs on women. Clear examples are provided in the selected extracts by three participants.

Participant 15 observes that her partner believes that witchcraft was the cause for his infertility, a common belief among rural folks,

“He said my mother took his underwear and took it to a witch doctor who put some muti and hid it somewhere tied so that she should have erectile dysfunction so that he cannot make any woman pregnant.”

Participant 16 weighs in by saying,

“I have always been subjected to cultural beliefs of using herbs and appeasing my husband by following his traditions. I am born-again. We always argue about these issues but am forced to follow to save my

marriage. At times we are asked to do all sorts of bad things which a Christian is prohibited.”

Similarly, Participant 10 says,

“He discouraged me from going to the church of my preference and he is choosing ZCC for me because ZCC allows people to do their rituals.”

Culturally, women are disadvantaged as they are always coaxed to follow their husbands' beliefs. This tends to be a source of conflict when women start questioning and demanding their right to choose which cultural and religious beliefs to follow. Men feel challenged by women's demands for their rights and use violence to stop women from making their own choice.

5.4.8. Subtheme 2.8. Disagreement about sexual intimacy positions

Very few participants raised the issue of sexual intimacy positions. There seems to be a difference between men's and women's preferences in sexual intimacy positions. These differences cause IPV among partners because men want to have it their way. Two extracts illustrate how sexual intimacy positions have led to IPV.

“The fight came in when we were to make love and he asked me to do things/styles that we have never done before, he forced me to do that and I was not enjoying that instead, I felt pain on the anal area Two days later he called me to come to his place during the day and he demanded sex, the same way he did during the weekend and I told him I am still hurting and I cannot do it any more he started to fight.” [Participant 14]

This extract shows that women are forced into positions in which they do not feel comfortable and, at times, feel powerless to refuse because they fear reprisals from their partners.

According to Participant 15, her partner uses drugs, making him violent during sex. They always disagree on what position to take as she is afraid of hurting herself during the act.

“I will not allow him to abuse me during sex. It is my right to protect myself from this monster. I do not want to end up with cancer. He can find another woman who can take that. I have on many occasions refused some of his sexual demands because I will be the one to suffer at the end.” [Participant 15]

5.5. Theme 3: Effects of IPV among women

Five major effects of IPV on women were identified, as displayed in Figure 5.5 and Figure 5.5.

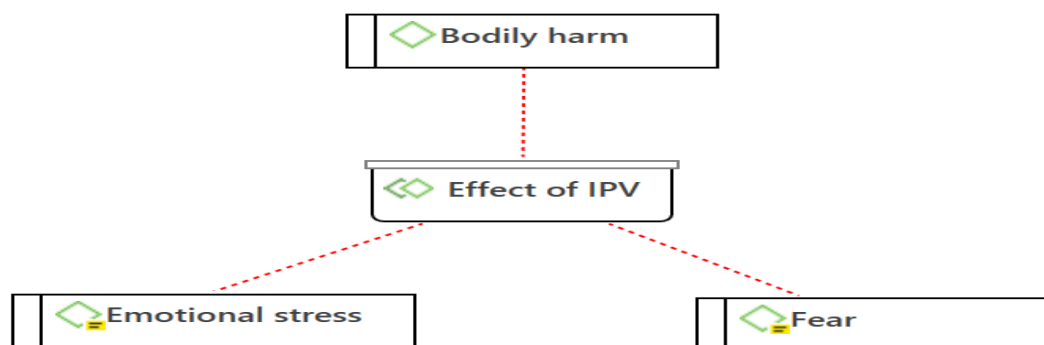


Figure 5.5: Effects of IPV on women

Name	Grounded	
◇ Fear~	<div style="width: 70%;"></div>	7
◇ Emotional stress~	<div style="width: 50%;"></div>	5
◇ Bodily harm	<div style="width: 10%;"></div>	1

Figure 5.6: Details of effects of IPV

The effects of IPV shown in the figures are examined under subthemes

5.5.1. Subtheme 3.1: Bodily harm

The findings show that some participants suffered bodily harm from physical violence, such as beatings and violent pushing by partners. Three participants attested that they were either severely beaten or pushed violently and sustained injuries. The extracts present evidence of this effect.

“Look at all the scars I sustained when he was biting me. I was still staying at Tshidzini Village. I became semi-unconscious and was taken to Tshilidzini hospital by the police and neighbour.” [Participant 6]

“My right hand has numbness since the day my partner twisted it when he was trying to take keys from me. I have been to the hospital many times to try to make it better, but that seems to be not working.” [Participant 11]

“I fell awkwardly on my back when he pushed me off the stairs after I caught him with another woman. Instead of protecting me with our child, he pushed me to save this other woman.” [Participant 13].

These findings indicate the nature of IPV affects women must endure to remain in a relationship with uncaring and violent partners. Despite sustaining such bodily harm, little seems to have been done to address the situation legally. Violence resulting in physical harm remains a problem in the communities where the study was conducted.

5.5.2. Subtheme 3.2: Emotional stress

One of the aftereffects of IPV is the emotional stress that both women and children suffer. The level of emotional stress seems to be very high, particularly among those women who have been sexually, verbally and physically abused and feel powerless to defend themselves from abusive partners. A few examples are in the extracts given.

Participant 1’s attestation shows that a high level of emotional stress affected intimacy with their partner.

“...all these fights and insults have reduced the level of our intimacy, and how I used to love him, he has become a stranger to me.”

The same sentiments are raised by Participant 4, who says,

“I do not enjoy sex with him since he started beating me and insulting me. I feel like he is someone who is raping me. I have lost interest in sex with him.”

One participant expressed that she overcame thoughts of committing suicide after being abused by her ex-partner, whom she loved so much.

“My experience with my first husband was terrible. I loved him so much but ended up regretting it. I considered killing myself after I found him in our bed with another woman. I went for counselling. Even now, I still remember it. It traumatised me.” [Participant 15]

Participants 2 and 11 expressed that IPV effects were detrimental to children who witnessed the abuses.

“The bigger impact is also on children who observe the abuse. It has a long-term psychological impact on the children. My children keep on asking why their father hates me so much.” Participant 2

Participant 11 also confirms that children are scared of their abusive fathers.

“I have realised that my children are always scared of their father. Whenever he returns from work, they go to their rooms on the pretext of reading. They have been exposed to his violent behaviour. They tells that he is not their biological father. This traumatises them a lot.”

These few extracts show that women and children exposed to IPV constantly face emotional and psychological stress, which may last for some time if not addressed.

5.5.3. Subtheme 3.3: Fear of partner and community

Traumatised individuals always live in fear of the perpetrators of violence. Fear of violent men and other community members continues to haunt the affected women and children, as indicated in the selected extracts.

Participant 1 indicated that she was *“not free around him because he may abuse her again”*. Furthermore, Participant 4 said, *“I sometimes see him in my dreams coming to kill me.”* This indicates that the participant hallucinates due to the trauma from IPV she went through. Due to the fear of being laughed at by other community members and friends, Participant 2 spends most of the time trying to *“cover-up bruises and lying about the real reason for the bruises cause emotional damage and affect self-esteem”*. In this regard, her status in the community has been damaged, leading to emotional stress from being looked down upon by community members. Participant 6 also indicated that she is in constant fear of men in general and has adopted a cautious approach when getting into a new relationship.

“I am afraid to make relations. I am tempted to get someone who will excite me. The only time he gets intimate with me is when he comes home disappointed from his girlfriends, he will then forces himself to me.”
[Participant 6]

IPV has led some participants to hate their husbands' relatives who conspire to encourage the abuse. For example, Participant 8 said:

“I am bitter with my husband’s relatives who encourage him to abuse me and my children. They think that their relative is always right to what he wants, even insulting us. Even if he gets ill with his girlfriend, they blame him for not performing his duties properly. ...he is no longer performing his duties as a father in the house.”

Fear of other community members, such as church members, is a cause for concern for Participant 15, who is well-known in the village.

“Whenever my husband beats me, I am just afraid to tell anyone because this can be news among church members. They go around talking about me and my problems. This stresses me a lot. I would rather die inside.”

The findings show that IPV can lead to fear of men in general and partners in particular. The fear extends to other community members, and viricides tend to hide the abuse and suffer quietly.

5.6. Theme 4: Common strategies used to address IPV

Participants were asked about strategies they used to address IPV. Several strategies being used are displayed in Figures 5.7 and 5.8.

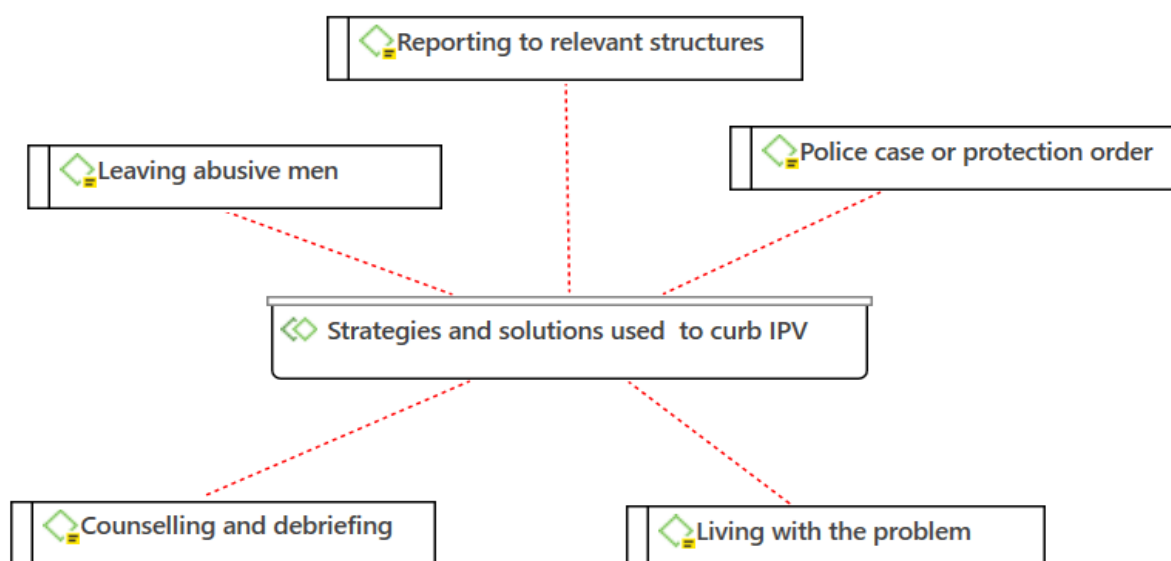


Figure 5.7: Strategies used to address IPV

Name	Grounded
Reporting to relevant structures~	12
Police case or protection order~	7
Living with the problem~	5
Counselling and debriefing~	5
Leaving abusive men~	2

Figure 5.8: Details of strategies used to address IPV

Figures 5.7 shows the general strategies used, while Figure 5.8 shows the preferences of strategies

5.6.1. Subtheme 4.1: Reporting to relevant structures

The most used strategy for IPV was reporting the violence to different structures, such as families/relatives, friends, church leaders and employers. This strategy was intended to resolve disputes and improve relationships between partners. Some participants preferred to report to the pastors and social workers. For example, Participants 1 and 4 took their grievances to pastors and social workers:

“I reported the abusive conduct to the family pastor, and he set him down and guided him.” [Participant 1].

“They must go to the social workers if they are not afraid or police station.” [Participant 4]

However, Participants 5 and 15 preferred to report to relatives to preserve their marriage and dignity:

I reported to my brothers who are in justice, one who is a lawyer, and another one who is a police officer. They both advised me to open a case. My brother who is a police officer in Gauteng contacted a colleague in Vuwani and I went there to explain to the sergeant so that

they can reprimand them, that they were not summoned to come, and it did not happen.” [Participant 5]

“I told my brother and I reported to his sister who is married because he does not listen to his parents when they speak to him to stop drinking because they say he is beating.” [Participant 15]

“I was forced by my friend to go to the TVEP so that I can get help from my sister-in-law who works there, I am always stressed, told her and my sister-in-law everything because I trust her, she listened to me and talked to my husband.” [Participant 15]

These extracts show that abused women sought assistance from different relatives and were told to report the IPV but were not given much help.

Reporting abusers to their co-workers and employers was another strategy used because these were structures available to the victims. This was in the hope that the abusers respected their employers and co-workers with whom they spent most of their time. Participants 3, 12 and 13 attested that they sought assistance from their co-workers and employees or those of their violent partners.

“I reported at his manager, and I was getting maintenance from his salary every month since 2018 and uses it to buy food.” [Participant 3]

“The alternative methods I used was to inform my core workers about my intimate violence, and I was relieved when I get emotional support from them.” [Participant 12]

“I don’t know where to go. My employer advised me to report him to his employer, I called his employer for assistance and told him everything bad about my husband.” [Participant 13]

These three extracts show the importance put on employers and co-workers in solving IPV.

5.6.2. Subtheme 4.2: Living with the problem

Some participants have accepted their fate and decided to live with abusive partners without taking action to remedy the problem. The decision to stay is to sustain the union despite the

challenges of IPV. Reference can be made to Participants 4, 6, 7 and 15, whose utterances are cited:

I am only staying because I got married in the community of property and if I divorce him, everything we have will be divided fifty-fifty, and the church members, as well as the colleagues at work, will laugh at me. The women in my area and my family will call me a returned soldier (Mbuyavhuhadzi), meaning someone who went back to his parent's home because she has failed in her marriage.” [Participant 4]

The Participant is constrained from leaving because she fears sharing property and exposing herself to community abuse. Women who divorce are sometimes scorned by their communities, which cascades down to their families being disrespected.

Participant 6 stays with the abusing husband because of her children she does not want to leave behind:

“You cannot believe what I’m about to tell you, because of love, I went back to my husband’s place because the kids live there. I cannot leave my children to live like orphans. I will do all I can to live with my children despite the bad behaviour of my husband.”

Participant 15 echoes similar sentiments by saying

“I did not report until now, years later because I needed help so that I can save my marriage, I love him and he is my first lover. We met in high school, so I will persevere until he changes”.

The motherly desires and expectations keep the women in broken relationships to foster children and preserve their social status at the expense of their dignity and humanity. This seems to encourage violent men to exert coercion on these helpless women.

Another participant believed that praying was likely to end her marriage’s sorrows and attested that she keeps praying to God to save her and the marriage.

“I only go to church when we have a dispute with my husband. I always feel much relieved by the word of God and prayer. God will do wonders on my husband some time.” [Participant 7]

Similarly, Participant 14 said that,

“I am a prayer warrior, and prayer will change him, I have hope that one day he will change and go to church, and will also get a job, these quarrels will be thing of the past...Amen”

While there are signs of optimism in prayers, the strategy is very pessimistic in that perpetrators of violence will take advantage of the reasonableness of the victims.

5.6.3. Subtheme 4.3: Police case or protection order

Some participants believed that they should open police cases for assault, while others sought protection orders against their violent partners. However, participants were quick to point out the deficiencies of this strategy as they found the perpetrators back at home.

Participant 2 has this to say about this strategy.

“I once applied for a protection order and found that it was not helpful because the intimate partner did not comply with the terms of the order. It made things worse.”

Participant 3 confirmed that she had her husband arrested:

“I knew that he was arrested because I reported him to the police the time he hurt me with a lasher, hoe, and axe last October.

In the same light, Participant 4 said:

“I report the abuser to the police and open a case so that he is arrested for life and they do not threaten the victims.”

“I laid charges on my husband and then was given protection order, but I felt sorry for him and have it cancelled.” [Participant 5]

These few participants were courageous to report their abusive husbands to the police. However, it will be appreciated that not all abusive behaviour can be reported easily to the police as women lacked evidence to prove the cases.

5.6.3. Subtheme 4.3: Counselling and debriefing

Some participants reported that they sought counselling services from psychologists, trauma centres, and churches.

Attestations by Participants 10, 13 and 14 indicated that the victims underwent debriefing and counselling by social workers and psychologists. Only Participant 14 ended up in a trauma centre.

“I then went to my aunt and told her what happened, who then took me to the trauma centre. I could not tell my mother because I did not know where to start.” [Participant 14]

Finally, Participant 6 benefited from the counselling by the pastor but never got married again,

“I went back to church and mother booked an appointment for me with the pastor who is still helping me until today with the counselling. I am still single until today.”

The findings show that few participants sought professional counselling services as they preferred other means.

5.6.5. Subtheme 4.5: Leaving abusive men

For extreme cases, two participants indicated that they eventually opted out of their marriages due to persistent IPV and failing strategies. Participant 6 had this to say,

“After counselling, my husband went back to his old ways of beating me, that is when I decided that enough was enough. Because I am physically weak, I decided to stand up and fight abuse by leaving that man.”

Participant 14 gave up on her marriage after surviving the beating and escaping.

“My marriage was falling apart due to the extreme violent behaviour of my husband. After trying everything to solve the problem, I had to escape through the window to save myself. I will not go back to live with someone who always bullies and beats me every time.”

The foregone discussions have revealed that several strategies used by victims were contextual to their situation and the nature of the IPV involved. However, the services utilised when resolving these misunderstandings were the police, counsellors, psychologists, family members, pastors, co-workers and employers. The effectiveness of these services is examined in the following subsection.

5.7. Theme 5: Challenges posed by strategies used to address IPV

The previous section presented strategies used to deal with IPV by various participants. In this section, the challenges of the strategies used are briefly examined so that their use is justified or refuted. Five challenges to the strategies used to address IPV were identified and illustrated in Figures 5.9 and 5.10. Each challenge is treated as a subtheme.

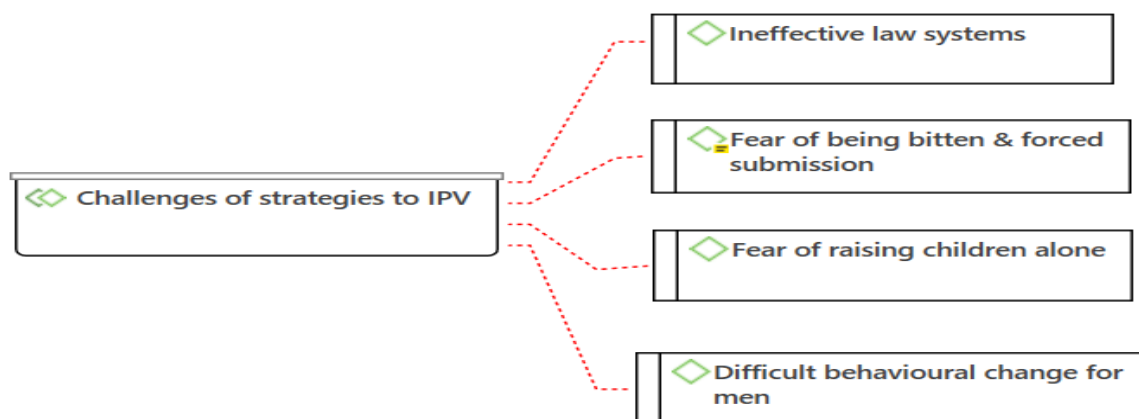


Figure 5.9: Challenges of strategies used to solve IPVs

Name	Grounded	
◇ Ineffective law systems	█	4
◇ Fear of being bitten & forced submission~	█	3
◇ Fear of raising children alone	█	3
◇ Difficult behavioural change for men	█	1

Figure 5.10: An itemised list of challenges to IPV strategies

5.7.1. Subtheme 5.1: Ineffective law systems

Strategies based on opening police cases, laying charges and obtaining protection against perpetrators have been reported ineffective by some participants who suffered IPV. Participants have cited challenges such as delays, inconsistencies, advantaging men, and

mistreatment of women who reported. These are extracts that confirm such assertions. Participant 2 purports that:

“The law takes too long to convict the perpetrators. They are usually given bail and this threatens the security of the victim. It is pointless to go to the court where the victim is proved wrong.”

Attestation by Participant 3 shows the ordeal the victim suffered:

“I went to the police station to look for my husband but the police said they do not know he had gone. They released him because there was no evidence of the said beating. When I showed them the medical reports, they laughed at me and told me to sort out my problem with my husband. They told me to be a good wife as the police was not a marriage counsellor.”

The magistrate’s court is also reported to be ineffective, as alluded to by Participant 5’s utterances.

On the first day, I was told to go to the magistrate and I found, the clerk of the court, I explained to her my situation with my husband that he beats me and he wants to kill me. When I reported my husband and brother, the clerk, a [woman] said I was mad, she had no time for false accusation. She asked me to leave as she had a lot of work to do. No protection order will be given against my husband.”

Participant 14 was convinced that men who abuse women could get away with the crime because they had money to bribe the police to write false information or drop the cases.

“I tell you, my friend, that cases of violence against women are not taken seriously by the police, even the courts. Men get bail or caution, given light sentences in these courts. The police intimidate women when taking statements to protect their colleagues. I think because many have money, they can bribe the police and court to overlook the evidence given.”

Finally, Participant 15 believed that even if men were arrested and incarcerated, women were subjected to harassment by the police or the friends of their husbands.

“At times, it is better not to report the case because the men will go to jail, but his friends or even the police will torment you. Men can still organise with friends while in prison to have you tormented by relatives and friends. The law does not protect women against these forms of victimisation”.

These few extracts show some challenges that victims of IPV face in the justice system, which is supposed to protect them.

5.7.2. Subtheme 5.2: Fear of being bitten and forced submission

Some IPV victims chose to remain silent because they feared being victimised by perpetrators. Therefore, they chose to be submissive.

“...praying and being submissive help me a lot because my partner wants to be listened to.I have to put him first and swallow my pride which is a difficult decision but I have to go through that to save our relationship.”
[Participant 1]

“I cannot report because I am afraid of him, he will harass me and my relatives.” Participant 4

“The last thing I want is for him to get out of prison and then hunt me down. He is dangerous. I will rather stay out of trouble by keeping quiet.”
[Participant 7]

These extracts indicate that IPV victims were prepared to endure the pain because they were afraid of further victimisation if the alternative strategies failed. Even at some trauma centres, counsellors tend to side with men. This is evidenced in the utterances by Participant 11,

“My husband was called at the trauma centre by the counsellor, and he indicated that the problem was solved and it was a little misunderstanding between the husband and the wife and he loves me.”

It would seem from the extract that the counsellor was speaking on behalf of the couple but putting the victim in a precarious position. It is unclear whether the victim was healed and why the counsellor claimed that the victim was traumatised by a slight misunderstanding when there was evidence of persistent beating and intimidation.

5.7.3. Subtheme 5.3: Fear of raising children alone

Some participants feared using drastic strategies for fear of raising children by themselves. The attestation by Participants 8 and 12 indicates why they opted to remain quiet at times.

“When my husband leaves me, I will struggle to raise these children. Maybe, I give it some time and then leave when they are grown up. I have nowhere to go.” [Participant 8].

“I have seen that single mothers who have not employed face challenges in raising their children. In the end, these children grow up without knowing their father.” [Participant 12].

5.7.4. Subtheme 5.4: Difficult behavioural change for men

The ultimate challenge raised by the participant was the difficulty associated with changing the behaviour of violent partners. Participants 13 and 15 expressed that dealing with men involved in drinking, womanising, and crime was difficult.

“I tried to talk to my husband to stop drinking and having many girlfriends, but keeps on promising, yet returns to his old ways of behaving. His behaviour is difficult to change. He pretends but forgets when I have relaxed and trusted him.” [Participant 13].

“I keep guessing on the next step of my husband. His behaviour is unpredictable. He listens to the pastor, but he does not follow up with exemplary behaviour.” [Participant 15].

5.8. Theme 6: Suggested strategies for IPV

The ultimate theme for the qualitative strand was strategies that participants thought could help combat IPV being experienced, see Figures 5.11 and 5.12.

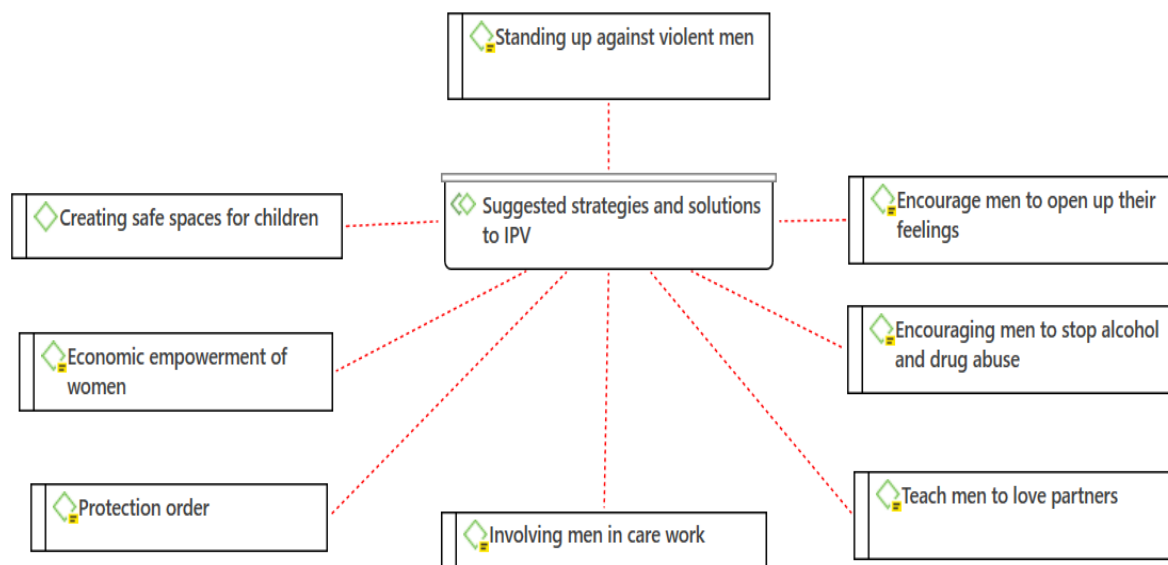


Figure 5.11: Suggested strategies for coping with IPV









Name	Grounded	
Standing up against violent men~		8
Economic empowerment of women~		7
Teach men to love partners~		6
Protection order~		2
Involving men in care work~		2
Encouraging men to stop alcohol and drug abuse~		1
Encourage men to open up their feelings~		1
Creating safe spaces for children		1

Figure 5.12: Detailed list of suggested strategies for coping with IPV

Each of the eight suggested strategies is briefly explored as a subtheme.

5.8.1. Subtheme 6.1: Standing up against violent men

This was the most popular strategy suggested by participants. According to some participants, women, with the help of the community, need to stand up against any form of IPV in their communities using any form of reaction which is non-retaliatory. Participant 4 suggested

“.....sleeping in separate rooms from the that of the perpetrators as well as women being taught how to stand up for themselves when they are being attacked or abused.”

This strategy of using different rooms was also suggested by Participant 9, who said, *“I sleep in my kids’ room to avoid unnecessary confrontation.”*

According to Participant 3, one way of protecting oneself is to leave the room once he shows signs of violence.

“I leave my husband when he starts cheating with other women or becomes violent towards me and my children. There is no reason to wait until he harms me.”

However, Participant 14 suggested that women need to defend themselves if left with no option physically.

“My view is that women look up to no one to assist them, but take upon themselves to defend themselves against brutal men. There is a time when one should say no and mean no. Refuse to be shoved around and stand your ground against violent partners”.

According to Participant 4, *“there should be some courses in which women are taught to recognise the early signs of abuse so that they take necessary steps.”* Participant 9 goes further to suggest that

“Women need to be taught how to stand up against abuse and to believe in themselves and assist each other and start something to live for and stop depending on men for resources.”

5.8.2. Subtheme 6.2: Economic empowerment of women

The study found that IPV perpetrators take advantage of poverty to dominate and subdue women. Because of this, some participants suggested the need to economically empower women to free them from economic subjugation by men. Extracts from most participants support economic empowerment strategies. Participant 1 says that,

“Women must be empowered by getting innovation programs which can strengthen their self-confidence.”

Participant 2 echoes similar sentiments by saying that,

“Empowering rural women economically can help reduce their vulnerability to abuse and strengthen their independence. Many programmes support women’s livelihoods in smallholder farming, fishing, livestock-keeping and rural entrepreneurship.”

Participants 10 and 12 believe that economically empowered women are less likely to be abused by men because they will be independent of cultural beliefs imposed on women by the communities dominated by men’s ideas. To be economically empowered, Participant 15 thinks that

“Women start with stokvel raising own money then save to venture into viable businesses by exploring potential areas of viabilities.”

However, Participant 15 laments that abused women face challenges when working in groups because they are sensitive to gossip and other women's matters.

5.8.3. Subtheme 6.3: Teach men to love partners

Some participants believe that men must be taught to love and care for their partners. Participants 1, 4, 8, and 9 think it is possible to make men realise how important it is to love and protect their female partners. The extracts from these participants indicate how they believe.

“I think all intimate partners must learn how to love their women and appreciate them and stop being violent and inferior.” [Participant 1]

“The perpetrators must be taught to love women and take care of the women and not to cheat.” [Participant 4]

“All men must love and respect their women and children and stop the violence and abuse of women and children”. [Participant 8]

“He must learn to love me and the kid as we are his family and not abuse me emotionally and not force when I say I don't want to have sex.” [Participant 9]

This approach focuses on changing the abusive men's attitudes towards women and providing support and needed love. However, the participants failed to provide how they would achieve this behavioural change.

5.8.4. Subtheme 6.4: Requesting for strict enforcement of protection order

Despite the challenges about legal solutions alluded to in previous sub-sections, some participants still insist on using this strategy to address IPV. Participants 11 and 13 believe that a protection order is an effective approach to addressing IPV.

According to Participant 11,

“Applying for a protection order puts women in an advantageous position in the event the case goes to court due to repeated violation. I will have something to fall on if I take a drastic stance. I know that some men may not

comply, but it is still a legal requirement which a victim can ask the court to enforce.”

Participant 13 feels that the police can be compelled to restrain IPV perpetrators where protection could have been issued. The participant says,

“It is my legal right to be protected. The problem is that some women do not know how the protection order works. You need to be strong and stand up for your rights. If the police fail to enforce it, I can even open a case against the police.”

These findings show that the discretions in the enforcement of protection is due to a lack of proper legal knowledge by IPV victims who think that once they are granted the order, perpetrators will automatically stay away. Women need to be empowered in legal matters again.

5.8.5. Subtheme 6.5: Involving men in care work

Besides academic IPV strategies, participants are determined to see most men involved in care work so that they change their beliefs and attitudes to safeguard their marriages by respecting their partners. Participant 2 purports that

“Men’s greater involvement in care work can have benefits for women, children, and men themselves; and it can be linked with a reduction in rates of men’s violence against women.”

Participant 10 thinks caring men can choose constructive friends; therefore, involving men in care work will enable them to be responsible, including selecting friends. The extracts exemplify the notion conveyed by Participant 10:

“I would love to change his friends; they are a bad influence on him the rest will change. He is 59 and hangs around with middle-aged men who are not of his age, who are of the same age as his children from the previous marriage. And remember, he is misusing the pension money.”

The findings show that only a few participants believed men need to be actively involved in care work.

5.8.6. Subtheme 6.6: Encouraging men to stop alcohol and drug abuse

Alcohol and drug abuse are among the most prevalent causes of IPV, as reported in the foregone subsections. Participants suggested that encouraging men to stop alcohol and drug abuse can be a viable strategy to prevent IPV. Extracts from Participants 1, 7 and 11 convey the notion of encouraging men to reduce the abuse of alcohol and drugs.

“I think the communities should encourage men to reduce the intake of alcohol and discourage them from taking drugs.” [Participant 1]

Participant 7 adds to this by saying,

“If I had power, I was going to change the drinking behaviour of men. Most abusers want to hide behind alcohol and drugs; I will encourage them to stop drinking beer and abusing drugs”.

These participants view men who take drugs as the only abusers and fail to account for those abusers who do not consume alcohol.

5.8.7. Subtheme 6.7: Encourage men to respect women

Only Participants 2 and 14 indicated that IPV perpetrators do this in the guise of their inner feelings. The participants suggest encouraging men to show good feelings toward women would translate to respect. Men who have hard feelings towards women tend to disrespect them. Besides showing positive feelings towards women, Participant 14 suggests that IPV perpetrators should be invited to attend counselling sessions together with their victims.

5.9. Conclusion

The researcher presented findings and discussions in this chapter from the qualitative phase of the study, Phase 1b. Phenomenological analysis was applied to qualitative data, and the researcher presented the findings as themes and subthemes. The next chapter will present the findings of both quantitative and qualitative phases to make provision for the development of strategies that are needed to empower women to overcome IPV.

CHAPTER 6

FINDINGS AND DISCUSSIONS

6.1. Introduction

The purpose of this study was to develop strategies to empower women against IPV occurrences in the Vhembe district. To achieve this, Phase 1(a) of the study investigated the types of IPV experienced, the causes and the effects of IPV, the strategies used to overcome IPV and their shortfalls. Data were collected quantitatively. In Phase 1b, qualitative data were collected to explain and confirm the findings in Phase 1a. Quantitative data analysis was presented in Chapter 4, and Chapter 5 introduced the findings from the Qualitative Phase (1b). This chapter gives an explanatory confirmation of the findings from both Chapters 4 & 5, as well as the interpretation and discussion.

6.2 Explanatory confirmation of findings from Chapters 4 & 5

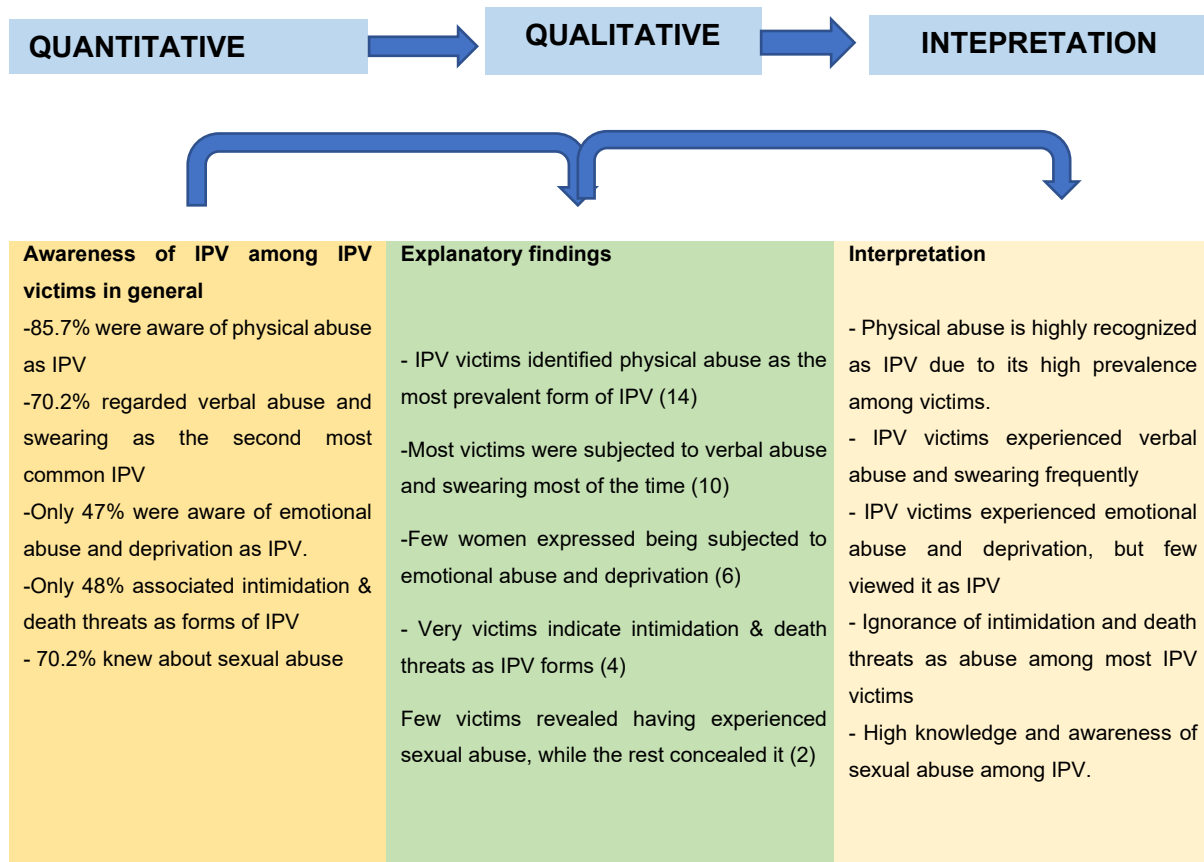
The explanatory confirmation of findings is organised into sections and subsections related to the following objectives of Phase 1a:

- To measure the level of general knowledge regarding intimate partner violence among IPV victims in the Vhembe district.
- To describe the victim's motivational attitude towards the acquired IPV information to act against any form of IPV behaviour in the Vhembe district.
- To assess the behavioural skills used by victims in dealing with any IPV occurrence.

6.2.1 Level of general knowledge regarding intimate partner violence among IPV victims in the Vhembe district

Table 6.1 illustrates the explanatory confirmation of findings of the level of knowledge of IPV among victims.

Table 6.1: Explanatory confirmation of findings on the level of general knowledge regarding intimate partner violence among IPV victims



Both quantitative and qualitative findings indicated a high level of knowledge about intimate partner violence among IPV victims in the district. The level of knowledge was indicated when IPV victims identified the type of violence experienced, its causes and its effects on them and their families, particularly their children. Table 6.1 presents the major types of violence IPV victims were subjected to by their intimate partners: physical abuse such as beating, bullying, shoving and isolation; verbal abuse, humiliation, and intimidation; sexual abuse including rape; emotional abuse; controlling behaviours; and material deprivation. At least 80% of the respondents and participants confirmed that they suffered from two types of IPV at the hands of their current intimate partners or ex-partners. Several studies report that women in South Africa are becoming aware increasingly of different forms of intimate partner violence, which they previously regarded as general forms of violence, but most choose not to report (Gordon, 2016; World Health Organization, 2012; Frade & De Wet-Billings, 2019; Gass, Stein, Williams & Seedat, 2010). Similar to previous studies conducted in South Africa and elsewhere in the world, the findings of this study confirm widespread IPV in the district being studied, and most women had adequate knowledge of such forms of violence.

These findings are supported by attestations in the previous chapter where women have acted against their partners after the abuse. Those victims who chose not to report did so of their own free will, even after being encouraged to report the abuse. The World Health Organization (2012) reports that at the top of the list of intimate partner violence committed against women are physical, sexual, and emotional abuse and controlling behaviours by an intimate partner, usually men. The findings of this study were consistent with those reported in some studies that South Africa is ranked as one of the countries with a high IPV prevalence in the world because several women reported experiencing IPV at some point during their relationships (Fox, Jackson & Hansen, 2007; Sere, Roman & Ruiter, 2021). This study found correlations between different types of violence and their causes. Most of the victims (83%) who suffered sexual and verbal abuse linked it to physical IPV, intimidation, threats, and death. Statements, such as *"my partner twisted my hand"*, *"pulled me by the naked"*, *"forced himself on me"*, *"locked me in my room and took away the keys"*, *"I was emotionally abused"*, *"he broke furniture when he got angry"*, and *"he withdrew my salary without my permission"*, show how physical violence is used to perpetuate the men's dominance and entrenched cultural beliefs in the district. Garcia-Moreno (2005) reports the coexistence of different types of violence, such as physical IPV, associated with sexual and emotional abuse. A comparative study of 12 Latin American and Caribbean nations conducted by Bott, Guedes, Goodwin, and Mendoza (2012) shows that most women (61–93%) who reported physical IPV indicated that they experienced emotional abuse as well. A multi-country study by WHO on IPV reveals that 23–56% of women experienced sexual IPV after physical abuse. According to Bott et al. (2012), IPV is a world pandemic and a violation of women's human rights, which needs to be addressed to reduce escalating cases of femicide. In South Africa, IPV has reached such alarming levels that it receives government attention as it is part of gender-based violence (Mthembu, Mabaso, Reis, Zuma & Zungu, 2021). A study by Joyner, Rees and Honikman (2015) reports that South Africa has the highest prevalence IPV related murder, in which half of the number of female murders are committed by their intimate partners. Gordon (2016) observes that IPV remains a silent epidemic in the South African public health system, regardless of progressive reforms in the constitution, legal system, and the implementation of a Victim Empowerment Programme. From the findings made in this study and the reports in existing literature, IPV seems to be entrenched in South African societies for many reasons. The findings on the causes of IPV in the unit of study are discussed in the subsequent section.

6.2.2. Causes of IPV

The causes of IPV among intimate partners, which were investigated, are depicted in Table 6.2.

Table 6.2: Explanatory confirmation of findings concerning causes of IPV



QUANTITATIVE	QUALITATIVE	INTEPRETATION
<p>Perceptions about causes of IPV among victims</p> <ul style="list-style-type: none"> - 89% of the victims identified differences in cultural beliefs as the main causes of IPV - 85% believed that disagreement on misuse of money led to IPV 83 % Mistrust due to infidelity issues - 79% suspected that low self-esteem & jealousy by partners led to IPV abuses - 78% of cases of IPV attributed to alcohol & drug abuse by partners - 78% of IPV victims perceived bad influence by relatives & friends among the factors that led to abuses -75% Disagreement about sexual intimacy issues 64% Despises wife and attire - 52 % of unemployment issues 	<p>Explanatory confirmation</p> <p>In very few did victims experience IPV due to differences in cultural beliefs (14)</p> <p>Victims experienced a recurrence of IPV abuses due to disagreement on misuse of money (5)</p> <p>IPs mistrust due to infidelity issues triggered violent arguments that led to physical or verbal abuse of the women (8)</p> <p>Described partners with low self-esteem & jealousy easily resorted to IPV in most cases (7)</p> <p>IPV partners who consumed alcohol & abused drugs were described as temperamental and confrontational (7)</p> <p>Description of cases where bad influence by relatives & friends led to abuse when the male partner wanted to assert influence and control over the female partner or embarrassment- 4</p> <p>Male partners abused female partners whenever there were disagreements about sexual intimacy positions. Male wanted to have their way (2)</p> <p>Victims expressed concern about the manner their partners disgraced them due to structure or attire (2)</p>	<p>Interpretation</p> <p>The dominance of male partners led to the use of excessive physical and emotional means to control women</p> <p>Minor misunderstandings between males and women led to abuse of females in several instances</p> <p>Sources of misunderstanding were:</p> <ul style="list-style-type: none"> - Drunkenness of male partners - Jealous of male partners - Lack of appreciation of women by male partners - Disagreements about financial issues - Unreasonable demand on sexual position by men - Unemployed men being critical of their female partners - Disrespect for women's attire and body structures

Mostly unemployed male partners easily abused their female partners for trivial issues. Unemployed males engaged in alcohol abuse (4)

The knowledge about the causes of IPV among the victims was apparent from the findings of this study. Findings show that the main causes of IPV in the district were due to several factors that IPV victims mentioned. According to the findings, *alcohol and drug abuse* was the main cause of IPV by partners or ex-partners who took these substances in excess to get the courage to confront their victims. Most of the IPV victims (65%) indicated that their intoxicated male partners abused them on several occasions. A report by WHO (2012) found that alcohol uptake was responsible for most cases of IPV incidences experienced by women in a developing country. A plethora of literature supports that men's abuse of alcohol and drugs exposes women to several IPV risks that need to be addressed (Hindin, Kishor & Ansara, 2008; Kishor & Johnson, 2004). Some of the utterances from the interviews showed that IPV victims were concerned with their partners' alcohol intake: "*He abused only after taking alcohol*", "*He used mbanje (dagga) whenever we argued*", "*He spent most of his time drinking and smoking with his friends then the beating started*", "*He became vocal after taking alcohol and started calling me names*", and "*He became a sexual maniac after taking drugs and forced himself on me on many occasions*". These extracts supported the notion that some perpetrators of IPV deliberately got drunk to abuse or harass women. Alcohol use, particularly heavy drinking, in which large quantities are consumed per time, is associated with more severe male-to-female IPV across different cultures (Wilson, Graham & Taft, 2014; Bushman, 2013; Foran and O'Leary, 2008). It is conclusive from the finding of this study and existing literature that alcohol plays a causal role in aggression and IPV in South Africa and elsewhere in the world. However, some authors argue that alcohol may not cause violence but escalate it among men with violent behaviour (Graham, Bernards, Wilsnack & Gmel, 2011).

Another major cause of IPV was the *infidelity* of both or one partner. Women were physically, verbally or emotionally abused for being suspected of cheating on their intimate partners, catching them cheating or being suspicious of their partners cheating. Any of these three-situation led to molestation or death threats. IPV perpetrators usually behaved violently on the pretext of being drunk and asked for amends later. Abusive male intimate partners felt jealous whenever their female partners talked to other men they knew. The women were accused of being promiscuous and subjected to abuse whenever their male partner was influenced by his relatives. This finding is consistent with Nemukuyu (2021), who reports that suspicions of

infidelity are a major cause of violence against women regardless of who has been in the wrong. These findings are similar to those made by Nemeth, Bonomi, Lee and Ludwin (2012) on sharp violence incidence due to infidelity counteraccusations between partners (both or one) under the influence of alcohol or drugs. In most cases, the IPV victims sustained significant injuries, such as severe head trauma (leading to hospitalisation or surgery), bite wounds, strangulation complications, and lost pregnancies (Nemeth, Bonomi, Lee & Ludwin, 2012).

Studies report different types of infidelity: Extramarital infidelity, where a married person has a sexual relationship with someone other than the married or cohabiting partner, or two partners who have part sexual intimate where another still feels they have the rights (Conroy, 2014). Studies conducted in sub-Saharan Africa, including South Africa, found that marital infidelity was connected to physical abuse in several ways, with a strong link to normative gender roles. According to Utley (2017), infidelity by one partner in a serious long-term relationship is usually considered relational devaluation by the other partner. Leary (2001) states that relational devaluation is a form of rejection and hurt when one partner's actions undervalue the relationship that the other partner desires or when one partner feels their relational value has decreased. Similarly, this study found that IPV victims' intimate partners felt betrayed by the victims, whether still in a relationship or out of the relationship, which caused a lot of tension and led to different forms of abuse. Literature shows that men having concurrent sexual partners tend to exhibit sexual conquests and male dominance, making them more prone to physical violence when questioned by either one of the partners on their infidelity behaviours (Boonzaier, 2005). Furthermore, IPV victims who suspect that their intimate partners have extramarital sexual partners were found to act violently towards them due to jealousy and fury (Karamagi, Tumwine, Tylleskar & Heggenhougen, 2006). In response, men tend to use violence when responding to accusations of infidelity (Stith, McCollum, Amanor-Boadu & Smith, 2012). Furthermore, studies have found that intimate male partners who suspect their female sexual partners of infidelity act violently to reclaim authority over "disobedient" women (Kim & Motsei, 2002). In this study, IPV victims suspected of being promiscuous were at a high risk of being physically, verbally and emotionally abused by their intimate partners. Strategies to deal with IPV due to suspected infidelities should include collaboration with the local communities.

The knowledge of IPV victims due to *societal norms and cultural and religious beliefs* was appreciably high, with more than 58% of the respondents having been affected. There are situations where intimate partners coerced IPV victims into following their customs due to societal norms and cultural beliefs. Male intimate partners forced women to accept their

traditional beliefs and practices to show dominance over women. In another incidence, a participant reported having been compelled to consume food, such as pork, against her religious beliefs because of the social norms that women should follow what their in-laws believed. This applies to infidelity, where men are treated as heroes for having extramarital status while women are treated as villains (WHO, 2012). Culturally, married women need to lose their identity and adopt, without question, the beliefs of their husbands' families. In corroboration, studies show that patriarchy, a dominant aspect of the social-cultural circumstance, always treats men as the head of the family while women are submissive subjects (Kyegombe, Stern & Buller, 2022; Ssetuba, 2005). Similarly, the study's findings confirm culturally accepted practices that men are men and can have as many women as they want because they are believed to be hypersexual, thereby normalising men's sexual engagements outside marriage (Kyegombe, Stern & Buller, 2022; Conroy, 2014). A study by Do, Weiss and Pollack (2013) reports that patriarchal gender beliefs about the social justifiability of wife abuse were related to an increased risk for IPV at both the individual and community levels.

Concerning *societal norms and cultural beliefs*, women in this study felt that the negative influence from relatives and friends contributed to IPV as these sided with the male intimate partner regardless of the flaws in decisions being made. The finding of this study shows that what is culturally tolerable can be considered abusive by other societies operating outside the culture. Corrective measures to address the situation are needed to stop IPV.

Some IPV victims, particularly married women who were employed or had a stable source of income, were explicit that disagreements on money issues were the cause of the violent behaviour of their intimate partners. Sentiments, such as "*I was bitten for asking why he withdrew money from my account*", "*I was insulted when I refused with money my brother gave me*", and "*He forced me to return the dress I bought with his money*", indicate how money issues lead to IPV against women and are usually accepted in African societies. There was a tendency by intimate partners to withdraw money from the IPV victims' bank accounts without their consent. Most of the economic relationships and abuses were related to poverty and unemployment of both intimate partners. Unemployed men harassed women for their money and forcibly withdrew cash, which they sometimes spent on alcohol or with other women. According to Fisher-French (2018), economic abuse is common in South Africa. It takes many forms, and the abuser forcibly controls the victim's money or other assets, eventually leading to violence whenever disputes occur. Similarly, women in this study claimed that men entered into a relationship with financially stable women but later tried to control their finances violently. A study by Bonnes (2016) in Malawi reports a high prevalence of IPV violence in which women

are bitten for having used their partners' money with or without consent. Surprisingly, men assume that their female partners' money is theirs and can use it without permission (Bonnes, 2016, Nemukuyu, 2021). The four hypotheses of a study by Choi and Ting (2008), namely the dependence, submission, compensation and transgression hypothesis, can be used to explain the form of IPV observed in this study which arises from economic abuse. The dependence hypothesis shows that economically dependent women in this study were more likely to face IPV because of the unjust decisions made on their behalf by their husbands, who had income and other resources to manipulate the victims (Hoque, & Makinoda, 2011; Young & Li, 2010). Most of the women in this study were poorly educated, without reliable income and had limited chances of leaving abusive husbands because they had no means to survive or support their children outside the abusive relationship. Studies have also proved that women with a higher economic status than their intimate partners were likely to suffer more IPV violence as they could not be submissive. However, such women were free to leave abusive partners to start a new life (Ackerson & Subramanian, 2008; Lawoko et al., 2007; Young & Li, 2010). Women who chose to be submissive to abusive men suffered more IPV, a result speculated by the submission hypothesis. According to Choi and Ting (2008), women are expected to be submissive to their husbands in traditional African societies, and men can do what they want with these women. Therefore, by asking their partners about the withdrawals of money, women showed some form of transgression that goes against the norms of traditional African societies, thereby increasing the risk of IPV. Similarly, abusive men unable to fulfil their familial duties usually compensate with violence against their female intimate partners (Choi & Ting, 2008; Jewkes, Dunkle, Nduna & Shai, 2010). According to the compensation hypothesis, economically independent women can reject subordination in the relationship, thereby threatening the male partner and leading to increased IPV (Choi & Ting, 2008). From these findings, it could be concluded that women can be subjected to IPV regardless of their economic status as men show their violent behaviour toward either a submissive victim or those who reject men's dominance. However, women who are educated and economically independent of men can leave abusive relationships more easily than those who are poor. A report by Nemukuyu (2021) confirms that 1351 divorce cases filed in various courts in Zimbabwe were mainly due to infidelity claims and conflicts linked to finances in which women were physically or emotionally abused.

The findings indicate that IPV was driven by *jealousy and low self-esteem among male perpetrators* who wanted total control of the IPV victims. Participants strongly felt that their intimate partners got irritated when they saw women speaking to other men. The findings show that men who were jealous of their partners felt belittled by spouses or girlfriends and resorted to all forms of IPV. For example, less educated men felt threatened by their intimate partners'

educational status and constantly reminded the women that education was unimportant in marriage. “*He told me that I was behaving awkwardly because I was educated.*” “*He always derided me in front of his friends and that my education was useless as I could not think properly.*” These and other sentiments echoed by IPV victims in this study show these women's dire level of hopelessness. Findings in other studies show that a male identity crisis led to low-self esteem among violent men and manifested as male dominance where the IPV perpetrators wanted to gain control over women (WHO, 2012, Gordon, 2016). Jealous men tended to use several uncouth tricks to subdue unsuspecting women (Kyegombe, Stern & Buller, 2022; Mullen, 1996). A study by Kyegombe, Stern and Buller (2022) concluded that jealousy led to relationship challenges, such as a breakdown of trust, quarrels about resources, conflict, controlling behaviours, and ultimately, physical and emotional IPV. A study by Chaddher and Ahmad (2020) established that a significant correlation existed between low self-esteem and the tendency to be violent among perpetrators of IPV. These findings reveal that the IPV perpetrators with a high tendency of violence were those with very low self-esteem, resulting in them acting violently against their intimate partners who challenged them.

This study revealed that the last factors causing IPV were *lack of communication* between intimate partners and *negative influences from relatives and friends*. There were cases where IPV victims complained about not receiving attention from their male intimate partners who spent most time away from home, and when they returned, they always chatted online. According to Nemukuyu (2021), the use of smartphones is now another major source of marital conflicts and violence because people spend more of their time on social media than with their partners. This implies that social media is fast destroying communication in several marriages and relations because spouses spend most of their time chatting with friends outside their homes. There is no effective communication that occurs between partners or spouses. However, when women engage in online chatting, their intimate partners become angry and order them to stop or confiscate smartphones. According to Rada (2020), limited or poor communication among family members and high levels of dissatisfaction about key issues often leads to high IPV prevalence in all categories that might provoke emotional distance, lack of intimacy and violence. This means lack of communication between partners can result in suspicions, anxiety and violent behaviour.

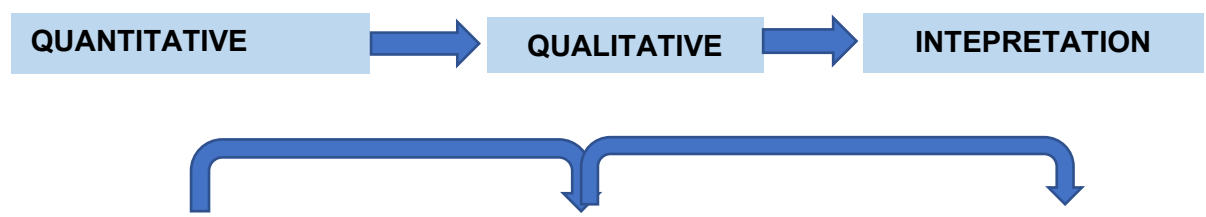
Finally, the study found that the negative influence of IPV intimate partners from relatives and friends was another factor that accounted for the violence between partners in an intimate relationship. Findings from the quantitative phase show that close to 70% of the respondents believe that family members and friends badly influenced their intimate partners. This was corroborated by findings in the qualitative phase where sentiments such as “*He only starts*

harassing me when his sister is around” and “His sister encourages him to get another woman”. “His relatives call him a useless man for staying with a barren woman” and “His friends are a bad influence” show that relatives interfere with the relationship of the two partners. The male partners then try to appease their relatives or friends by abusing their partners. Studies of IPV by Mead and Kelty (2018) among intimate students reveal a serious contribution to violence by relatives or friends of either partner who are ganging up against the female partner. The study report that in most cases, friends and relative characterise the female partner using offensive language, which causes the male partner to be furious and act violently. There was a case whereby the participant expressed that her friend was jealous of her relationship and kept stalking her male partner, trying to convince him to leave the relationship based on past infidelity. Another participant pointed out that her partner’s friend persistently reminded him of the *“miscarriages which the women experienced due to the suspected witchcraft of the woman’s grandparents”*. Of particular interest to these findings is that the male was influenced by relatives more often than female partners, indicating that the latter put much consideration and thoughts into the potential adverse effects of friends’ influences in the relationships. Male partners easily fell in with the influence, leading to a high risk of IPV on their intimate partners.

6.2.3 Effects of different IPVs on women

The effects of different IPVs on women are shown in Table 6.3.

Table 6.3: Perceived effects of IPV among Victims



QUANTITATIVE	QUALITATIVE	INTEPRETATION
<p>Perceived effects of IPV among victims</p> <p>71% of the victims' emotional stress and trauma</p> <p>68% mentioned the fear of verbal abuse and harassment</p> <p>59% Bodily harm from physical abuse</p>	<p>Explanatory confirmation</p> <p>IPV victims expressed having experienced emotional stress and trauma after being subject to emotional and sexual abuse (12)</p> <p>Being embarrassed in front of family members and friends after being verbally or physically abused – (8)</p> <p>Victims experienced bodily harm such as scars, miscarriages after physical abuse – (4)</p>	<p>Interpretation</p> <ul style="list-style-type: none"> - Loss of interest in the relationship due to emotional stress. - Isolation after being embarrassed in front of friends. Loss of interest in everyday activities due to depression. - Seeking medical attention for scars and health issues from physical and emotional abuse.

Besides knowing different forms of IPV, the study also found that the victims of IPV knew some effects of various cases of abuse they have been subjected to. Findings from the quantitative phase corroborated by findings from the qualitative phase confirm that IPV victims were aware of the types of effects they suffered from as a result of IPV experiences. The major effects of IPV were categorised as bodily harm, stress, trauma, fear, loneliness and hatred of men. The findings show that 80% of the IPV victims suffered minor to severe bodily harm resulting from physical abuse. Utterances such as *“I sustained a deep cut to my face”*, *“I cannot use my left hand after it was twisted and is numb”*, and *“my right eye no longer sees properly after being punched”* show that IPV victims still suffer from the aftereffects of violence. The World Health Organization (2012) reports various effects of IPV, including physical, psychological or sexual harm to those in the relationship. According to Duvvury, Callan, Carney and Raghavendra (2013), IPV has profound and far-reaching effects on the health, social, and economic outcomes of South African women because of illness, bodily harm, unemployment, intergenerational impacts, and intrahousehold relations of women. South Africa has a femicide rate of approximately four times the worldwide rate due to the contribution of IPV (World Health Organization, 2016; Gordon, 2016). These findings are similar to those of a multi-country study by the World Health Organization (2014), which concluded that emotional distress, suicidal thoughts, and attempted suicide were noticeably higher among women who experienced IPV than those who had not.

Furthermore, literature shows that woman who continuously experiences IPV face increased risks of suffering adverse health outcomes (Richardson, Coid, Petruckevitch, Wai, Moorey & Feder, 2002), and this increase chances of an attempt of suicide (Gibbs, Dunkle & Jewkes, 2018; South African Police Service, 2016). A study by Maguele and Khuzwayo (2019) posits that young women subjected to IPV are more likely to acquire adverse health outcomes, including unwanted pregnancy, abortion, sexually transmitted infections, including HIV, injuries or being murdered. In this study, sexually transmitted diseases were reported by some participants whose intimate partners were promiscuous. Close to 95% of the respondents were worried that the sexual abuse suffered by women was likely to contribute to serious health issues. Women in this study indicated that they suffer stress from emotional abuse, and some ended up visiting trauma centres where they received counselling. Those who suffered bodily harm were admitted to hospitals. Overall, the aftereffects of IPV were child abuse and affecting the well-being of the families of the affected partners. Due to the persistent IPV, some victims felt that they were becoming powerless, socially isolated and falling into abject poverty

due to the stress and trauma they suffered. A study by Gordon (2016) reports that IPV victims were likely to have higher rates of unplanned pregnancies, abortions, miscarriages, preterm deliveries and stillbirths, and the effects could be visible well after the woman has survived the abusive relationship.

Some women applied specific strategies to overcome these abusive tendencies to defend themselves from IPV intimate partners and alleviate the effects of the IPV suffered. The common strategies women use to counteract abuse are discussed in the following subsection.

6.2.4 Explanatory confirmation of findings concerning behavioural skills used by IPV victims

Table 6.4 shows the integration of quantitative and qualitative findings on the behaviour and skills in coping with IPV among victims in the district.

Table 6.4: Explanatory confirmation of findings concerning behaviour skills used by IPV victims

QUANTITATIVE	QUALITATIVE	INTEPRETATION
<p>Traditional strategies to cope with IPV</p> <p>31.5% of the IPV victims indicated resistance to any form of IPV abuse as a strategy to overcome IPV.</p> <p>22.8% of victims believed in the use of the formal network to address IPV in the district</p> <p>Very few IPV victims (9.6%) believed that placating or pleasing the abuser was good</p> <p>The use of the legal route as an IPV strategy was unpopular as it was approved by only 8.9% of the victims</p>	<p>Explanatory confirmation</p> <p>Standing up against violent men (resistance) was suggested as an effective way of dealing with IPV behaviour - 8</p> <p>The idea of economically empowering women to be independent of men was put forward as another viable strategy to combat IPV- 7</p> <p>Some victims felt it necessary to teach violent men how to love their partners - 6</p> <p>Involving men in care work was another strategy that IPV thought was possible to solve the pandemic - 2</p> <p>Though victims seem to be sceptical about the protection order, some suggested its use in an improved way - 2</p>	<p>Interpretation</p> <p>Resistance and standing up against abuse and timely intervention by family members and pastors seem to be effective strategies in reducing IPV, but the latter (use of informal structures) is temporary.</p> <p>Financial independence and empowerment of women can reduce IPV occurrences because many women who were victims were not educated enough to get formal and good-paying jobs; they depended on their partners.</p> <p>Most respondents were of the view of reporting violent intimate partners to elders of the family, friends, pastors even employers so that they talk to them. These women thought</p>

<p>Only 5.0% of the victims approved informal networks as an effective strategy for IPV</p> <p>Safety planning was approved by only 3.6% of the victims as a strategy for solving IPV problems.</p> <p>18.5% of the victims indicated that all the strategies put forward by the research were ineffective in dealing with IPV behaviours.</p>	<p>Encouraging men to stop alcohol and drug abuse was proposed as a possible strategy to deal with IPV - 2</p> <p>Encouraging men to be open up about their feelings was seen as another potential strategy for IPV - 1</p> <p>Creating safe space for children was a strategy needed to cater for the being of the defenceless ones – 1</p>	<p>that by reporting to appropriate structures, the abusers would receive counselling or would be reprimanded.</p> <p>Due to ineffectiveness, victims were reluctant to pursue the legal routes as a strategy.</p> <p>Victims expressed that safety planning can assist, and perpetrators should be encouraged to talk about their feelings.</p>
<p>Perceptions of traditional strategies used to deal with IPV</p> <p>79 % of victims indicated opening a police case or getting a protection order</p> <p>71% indicated reporting to relevant structures</p> <p>52% indicated counselling and debriefing as a good strategy</p>	<p>Explanatory confirmation</p> <p>Victims opened police cases or obtained protection orders when the situation got out of hand [5]</p> <p>Victims reported the abuse to relevant structures such as the family, friends, or religious leaders when it got out of hand-[12]</p> <p>Seeking counselling and debriefing was the last resort by victims – 5</p> <p>Some victims were submissive, endured and stayed with abusive men - 7</p> <p>The last resort was leaving abusive men and returning to parents or relatives - 4</p>	<p>Interpretation</p> <p>Strategies being contextual to the IPV perpetuated:</p> <ul style="list-style-type: none"> - Police case if repeated or intense abuse. - Seeking advice from relevant structures, particularly a relative, to influence the abuser - Seeking counselling for both partners - Evaluating the benefits of the relationship and deciding whether to stay or leave
<p>Perceived challenges in strategies used in coping with IPV</p> <p>72% of victims believe strategies for behavioural change among male abusers were ineffective due to difficult behavioural change for men</p> <p>63% of victims feared that to use drastic strategies due to fear of being bitten & forced submission by violent IPs</p> <p>65% of victims feared raising children alone when they left the relationships</p>	<p>Explanatory confirmation of findings</p> <p>Victims who have tried to have men counselled found it ineffective in changing violent behaviour in the long term as men resorted to old ways of behaviour - 3</p> <p>IPV victims were not only in danger from abusers but the family and friends who continued victimisation even after trying to solve the problems. Whether victims submitted to abuse or not, the perpetrators continued with the abuse - 3</p> <p>Victims feared the stigma attached to leaving marriage or relationship as well as</p>	<p>Interpretation</p> <p>Victims were reluctant to pursue some of the coping strategies due to the ineffectiveness of such strategies</p> <p>Victims expressed having suffered possible serious consequences with some of the traditional coping strategies which are biased towards the abuser</p>

<p>63% indicated that the law was ineffective laws in dealing with abusive IP</p>	<p>raising children alone in these challenging economic times- 3</p> <p>Victims described the South African law systems as biased against women and IPV victims.</p>	<p>Victims feared for socio-economic consequences arising from leaving toxic relationships</p> <p>Victims were suspicious of how the law system works when abusers violated protection orders or even threatened them in front of the police/magistrates</p>
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The findings made in this study show that women used different strategies to overcome the IPV they suffered from intimate partners. The strategies used included: reporting to appropriate structures such as the family, pastors or employees; opening police cases and asking for a protection order; leaving or divorcing the abuser; and living with the problem. Most of the respondents (65%) were of the view of reporting violent intimate partners to elders of the family, friends, pastors even employers so that they talk to them. These women thought that by reporting to appropriate structures, the abusers would receive counselling or would be reprimanded. Some responses were: *“I reported him to his family who talked to him”*, *“We went to the church pastor to seek advice”*, and *“I was advised to report to his employer or immediate boss before going to the police”*. The use of such strategies is recommended in many studies with the belief that the strategy would have lasting effects on the IPV perpetrators ((Clark, Silverman, Shahrouri, Everson-Rose & Groce, 2010; Kohli, Perrin, Mpanano, Banywesize, Mirindi, Banywesize, Mitima, Binkurhorhwa, Bufole & Glass, 2016). In traditional communities, family members and friends can positively and negatively influence IPV. Family members, pastors and immediate bosses whom the perpetrator respects can reduce the tendency of IPV by negotiating a truce or using sanctions. Sanctions involve the perpetrator being isolated, fined or subjected to community punishment such as public discipline. Kohli et al. (2016) found that timely intervention by family members and pastors effectively reduced IPV temporarily. In South Africa, intervention by family members and outsiders seemed to escalate the violence, and the male intimate partners seemed intolerant to interference favouring the women.

The alternative strategy was to report to the police or get a protection order against the IPV perpetrators. IPV victims reported having been encouraged to report cases of violence to the police and get protection orders. This strategy was reported in a few studies conducted in South Africa (Peltzera, Pengpidde, McFarlane & Mercy Banyinig, 2013). IPV victims in this study were aware of the need to involve the police, lawyers and magistrates in violence cases. A study by Peltzer et al. (2013) concludes that opening police cases and obtaining a protection order is an effective short-term solution in preventing violence against women as perpetrators

tend to resort to violence with time. The authors also report that women found it cumbersome to obtain protection orders at the time as the police and even magistrates were reluctant after demanding a lot of evidence from victims (Peltzer et al., 2013). IPV victims felt frustrated and resorted to other strategies, such as leaving or divorcing the abusers or living with the problem, which brought about other challenges. Some participants indicated that the police or relatives asked them to withdraw the police case and settle differences with their abusers. Furthermore, participants voiced that the abusers violated the protection order or skipped court hearings and returned to threaten the victims. In some cases, the victim was threatened in the police's presence, and nothing was done to the abusers, but they reprimanded the victims for disrespecting their husbands or boyfriends. Because of this, some women felt that asking for legal protection was ineffective as the system favoured the abusers who had financial resources to bribe the system or get better lawyers to set them free. This finding shows that the application of law and legal systems in South Africa is not as effective as it is touted in solving IPV cases perpetrated against women. A study by Peltzera, et. al (2014) shows that lawyers of IPV victims reported violence to the police station and magistrates court, but nothing was done to the perpetrators.

In this study, leaving or divorcing abusers was mentioned as a strategy for IPV by close to 40% of women. Only a few abused women successfully left the abusers temporarily or divorced them. Despite successfully leaving the abusers, women returned to the same abusers because the communities shamed them for taking this stance. In traditional communities, leaving a marriage brought shame to the women and their parents for failing to provide good parenthood. Because of this, most women, particularly those economically dependent on the abusers, were unprepared to leave the marriage. Literature shows that in traditional communities, daughters are socialised to be good and obedient women and are expected to carry the symbol of honour for the family by following all prescribed roles despite the associated consequences (Milani, Leschied & Rodger, 2018). The stigma attached to divorce has a damaging and disparaging cultural notion to the family in the community (Hassouneh-Phillips, 2015). Due to this unpleasant stigma, women socialised to be submissive are prepared to make sacrifices to maintain family unity in protecting the marriage as much as possible (Haj-Yahia, 2016). To keep the family intact, IPV victims tend to keep family privacy and secrecy, including violence suffered, and this subsequently forces affected women from seeking formal support from local agencies (Milani, Leschied & Rodger, 2018). Most married women fear divorcing because they will leave a home, break up the family and fear living as a single parent. In urban centres, there seems to be less stigma on failed

marriages leading to empowered women leaving difficult marriages because they are financially independent of their husbands and have suitable support structures not found in many traditional communities (Nemukuyu, 2021). Finally, very few women were prepared to file for a divorce or take legal action against the IPV intimate partners.

Being *submissive and living with the problem* was another strategy IPV victims used due to some of the reasons already discussed in the foregone parts of this section. Sentiments such as *“I do not want to leave my children behind”, “he is my husband, he will change soon”, “I do not want to embarrass my family by leaving my husband”, and “I am not the only one affected, some are worse than me”* are given. *“I have nowhere to go when I leave him my parents are late”, “I have to swallow my pride and listen to him”, and “I drink alcohol to forget my problems”* indicate a hopeless situation that makes close to 56% of the IPV victims to choose to continue with a harmful marriage or relationship. These findings are supported by existing literature which shows that IPV victims who choose to stay in toxic relationships or marriages tend to ignore the problem by being submissive to the demands of the abuser (Hassouneh-Phillips, 2015; Milani, Leschied & Rodger, 2018). In this situation, the victim has to play a “good wife” role by agreeing to whatever the abuser wants to avoid quarrels. Submissive women had to admit to being wrong on any dispute-related issues and surrender their freedom and dignity to the abuser. Some coping strategies involved praying, taking alcohol or drugs, and being oblivious to the problem (Sere, Roman & Ruiter, 2021). A study by Sere, Roman and Ruiter (2021) posits that women who use alcohol forget the pain caused by mistreatment by abusers. Mpondo, Ruiter, Reddy and van den Borne (2016) call these non-formal coping strategies maladaptive coping responses and involve a lot of avoidance and acceptance. IPV victims pretended to be happy and comfortable with the abuse to stop the abusers from inflicting pain on them. According to Roman and Ruiter (2021), avoidance and acceptance strategies had their problems as they had the potential of escalating to violence when the abuser realised that the strategy was to deceive him into being a “winner” when in fact, he was a “loser”. Maladaptive strategies were used by women who needed to remain “loyal” to their abusive husbands and diffuse the tension while working on other strategies to buy time in the marriage or relationships.

Professional counselling is a coping strategy that relies on professional advice from different counsellors found in the area and at trauma centres. Findings show that a handful (33%) of IPV victims sought professional psychological counselling for themselves and their partners, but that was in vain after their partners failed to turn up or threatened them with severe punishment. For example, one participant said, *“Every time I arranged for counselling, he will agree but later came back drunk and threatening with death.”* Another said, *“His parents and*

aunt failed to convince him to attend a family agreed counselling with a local counsellor.” Only a few (27%) of the IPV victims went for counselling; the majority (54%) indicated that they did not know about professional counselling or simply did not have enough money to pay for the service. Some participants were hesitant because they mistrusted counsellors for leaking their secrets to abusers. Those who went for counselling followed the proper stages, while others went to the trauma centre for further treatment for depression. A study by Sere, Roman and Ruiters (2021) concludes that IPV victims who avoid counselling either downplay the abuse or evaluate it as normal without considering the likely future effects. One participant indicated that she stopped going for counselling when she felt shy about talking about domestic violence to nurses and doctors who were encouraging her to take domestic violence programmes. Participants were asked to recommend strategies they think should be implemented to curb IPV in the district. The next subsection is devoted to the suggested strategies.

6.3. Suggested strategies for IPV

In addition to conventional strategies used to cope with IPV, the study found that respondents and participants had preferred strategies, namely empowering women, reducing poverty in local communities, reducing alcohol and drug abuse, and including traditional leaders in reducing societal norms of violence.

This study found that most (87%) of the IPV victims were economically dependent on men because they were not educated to be formally employed. They relied much on child grants to supplement their partners' meagre income. IPV victims were also not able to deal with the effects of violence. Generally, women felt that some form of empowerment was needed to emancipate them from men by providing appropriate empowerment solutions, such as teaching them how to cope with violence; how to stand up to violent men; making them economically independent of men; providing community-based assistance where women can easily report violence without going to the police; educating women how to handle divorce issues; and providing free legal services for IPV victims. These suggestions are consistent with previous studies that propose the empowerment of IPV victims through various programmes. Sere, Roman and Ruiters (2021) suggest three possible empowerment programmes for IPV to deal with the effects of violence, namely,

1. Addressing structural barriers that women experience to effectively respond to the violent situation by having regular visits and events from various organisations to support IPV survivors in different places. For example, using simple communication tools to educate women about IPV and the organisations that can assist

2. IPV experts holding mandatory workshops with the police on how to assist IPV survivors to feel free to report violence without making unrealistic and unnecessary demands which discourage women from reporting the abuse
3. Provision of free medical check-ups and care in villages across the country

Such empowerment strategies should be used to identify IPV victims and refer them to counselling services that restore the dignity of abused women (Sere, Roman & Ruiter, 2021).

There was a suggestion by IPV survivors to encourage men to reduce alcohol and drug consumption in the local communities. Participants were of the view that if the community addressed the abuse of substances, this would reduce IPV. Existing literature suggests that intervention strategies focusing on reducing alcohol consumption and related harms are one of the potential factors most open to intervention and behavioural change (Babor, Caetano, Casswell, Edwards, Giesbrecht, Graham, Grube, Hill, Holder & Homel, 2010; Heise, 2008). According to Babor et al. (2010), one effective way of controlling alcohol consumption is limiting its physical availability and applying local interventions, including policing and enforcement policies impacting alcohol sales and service. In South Africa, alcohol is one of the substances most readily available in abundance at affordable prices. Reducing the availability of alcohol reduces consumption and IPV as the abusers put much more effort into locating it (Campbell, Hahn, Elder, Brewer, Chattopadhyay, Fielding, Naimi, Toomey, Lawrence, Middleton, 2009). Therefore, IPV can be reduced by decreasing the drinking frequency among IPV perpetrators. A good case involves the reduction in alcohol-related IPV during the COVID-19 lockdown in 2020. Wilson, Graham and Taft (2014) report that communities can apply strategies that address the drinking problems of individual IPV perpetrators so that they reduce their drinking habits. A study by Powers, Vedel and Emmelkamp (2008) found that couple-based alcohol treatment interventions effectively decreased alcohol consumption while enhancing relationships between married or cohabiting couples seeking treatment for alcohol and drug problems. However, some participants indicated that relatives and even the legal system tried to use alcohol-intervention strategies but only worked for a limited time, after which the problem recurred again. According to Wilson (2014), alcohol-related IPV is a complex, multi-dimensional challenge and has been neglected by research in intervention and prevention.

Modern strategies against IPV are ineffective in traditional communities without involving traditional leaders in reducing societal norms of violence. Most of the IPV victims in this study stay in villages under influential traditional leaders who may be aware or unaware of the abuse. Traditional leaders are the custodians of some cultural norms and beliefs, which can be

challenged through these leaders. Literature suggests the need for empowerment strategies that challenge the cultural beliefs about harmful gender roles disadvantaging women in general (Duvvury, Callan, Carney & Raghavendra, 2013; Mengo, Small & Black, 2017). Such strategies need approval from traditional leaders to be accepted and effectively implemented. Such initiatives are reported by Simmons, Halim, Servidone, Steven, Reich, Badi, Holmes, Kawemama and Messersmith (2019) in Tanzania, where community leaders are involved in most of the initiatives to reduce IPV among women. According to Simmons et al. (2019), traditional community leaders are valuable sources of community-specific interventions for IPV, which are usually overlooked because the modern legal system and the police are preferred. Traditional leaders understand the role of women in the community and have control of a greater degree of influence over men in their communities. This implies that any strategy seeking to challenge cultural norms and beliefs and having the approval of traditional leaders can be effective in dealing with IPV. Participants in this study recognised the role these conventional leaders can play in reducing IPV by encouraging men to stop applying outdated norms to the detriment of women. Traditional leaders are regarded as being able to eliminate some of the harmful gender stereotypes embedded in social and cultural norms which subject women to the whims of men and take gender-based violence seriously.

Finally, reducing poverty in local communities was suggested to empower women against IPV. Most of the IPV victims in this study were economically dependent on men, suggesting that women can be empowered by reducing poverty through different projects and employment. Studies recommend that effective interventions for reducing IPV should tackle gender inequalities and poverty by maximising the potential of women's economic empowerment interventions and overcoming challenges (Gibbs, Jacobson & Wilson, 2017; Abramsky, Lees, Stöckl, Harvey, Kapinga, Ranganathan, Mshana & Kapiga, 2019). In this study, participants felt they were subjected to IPV because of their poverty; therefore, by making them economically independent, they would be emancipated from abusive men. This means that IPV reduction strategies not only need to focus on reducing poverty in the communities, but also among the women subjected to violence. Poverty reduction strategies are time-consuming but can bring about a substantial needed reduction in IPV.

6.4. Conclusion

This chapter presented the discussions of the findings made in the study. The findings showed that IPV victims used various strategies to cope with the effects of the abuse. Some preferred to lay charges and seek protection, while others used relatives to try and diffuse the tension, leaving or divorcing the abusers, living with the situation, and seeking counselling. However,

the victims faced challenges with conventional coping methods as they found some very lengthy, expensive, unsupportive, and full of flaws that exposed them to further abuse. The failure of these strategies was due to factors inherent in the implementation and the interference by the abusers who were exploiting the weakness in the systems. Several strategies to reduce IPV have been suggested in this study.

The next chapter presents a set of strategies for IPV arising from this research and selected conventional solutions.

CHAPTER 7

DEVELOPMENT AND VALIDATION OF INTERVENTION STRATEGIES TO EMPOWER WOMEN AGAINST IPV OCCURRENCES

7.1 Introduction

This chapter is on developing and validating intervention strategies to empower women against IPV occurrences in Vhembe district, Limpopo Province. The intervention strategies aimed to provide solutions to IPV problems, improving a situation of abuse and IPV occurrences by an intimate partner. The researcher used findings of quantitative and qualitative as a basis to develop strategies to empower women against IPV.

7.2 Development of strategies to empower women against IPV occurrences

7.2.1 Methodology for intervention strategies development

A one-day workshop was conducted with four subregional managers from the Vhembe district as they are TVEP centres within the districts the study was conducted. The main purpose of the stakeholder workshop was to develop an evidence-based intervention strategy feasible or practical in typical community settings. However, because of COVID-19 restrictions, the team conducted a virtual workshop. A presentation was sent to the managers, after which the researcher presented the research findings in Chapter 6 to the stakeholders, who confirmed that the findings reflected most of the participants' ideas. Through stakeholder engagement and a review of the literature by the researcher, the team generated a list of strategies to address the problem of IPV in the local communities. The managers were requested to assess the proposed strategies and confirm the availability of the resources to implement the strategies to improve knowledge amongst victims.

The development of intervention strategies was guided by the Information Motivation Behavioural model (IMB), which is an intervention-oriented framework that combines aspects of social cognitive theory (Fisher and Fisher 2006) and other widely used health behaviour models (Fisher & Fisher, 2006) to reduce health-related risk behaviours, as outlined in Chapter 1. The IMB model of behavioural change was developed in 1992 by Fisher and Fisher to explain and modify HIV risk-taking behaviours (Fisher & Fisher, 1992). The IMB postulates that health-related information, motivation, and behavioural skills are important determinants of whether healthy behaviour is performed (See Figure 1.2). To adopt the prevention behaviour, people must have information which will translate easily into action, motivation to act, and skills to perform the behaviour. Suppose a person is well-informed, motivated to act, and has the necessary skills and confidence to act. In that case, he or she is more likely to

initiate and maintain the health-promoting behaviours which produce positive outcomes. Therefore, according to IMB, health interventions or strategies should be focused on: a) dispersing effective health information relevant to the target health behaviour and specific to the population; b) increasing personal motivation and social support; and c) skill-training to increase self-efficacy for performing healthy behaviour.

In this study, the IMB model is relevant as it focuses on issues of women empowerment in behavioural change. The notion of empowering individuals is discussed by Campbell (2003), who identifies three dimensions: provision of the information to assist individuals' rational health choices, motivation to perform healthy behaviours, and training them in appropriate behavioural skills. The IMB model is a valuable framework for conceptualising the gap between having knowledge or information about a problem and knowing what to do, and doing it. In the case of IPV violence prevention, these models would suggest that IPV victims need accurate information about the problem of intimate partner violence against women and the role women could play in preventing this violence. Women also require motivation to attempt behavioural change and the behavioural skills necessary to undertake this process (Crooks, Goodall, Baker & Hughes, 2006).

Accurate information about the problem is an essential building block in supporting individuals' transitions to healthy behaviour choices. Women and men need more accurate information about the issue of abuse of women and also about the day-to-day relationship challenges faced by their children. Accurate information is necessary; however not a sufficient condition for engaging women and men in preventing intimate partner violence. Another critical piece of the picture is motivation. In addition to the information and motivation, behavioural skills are required for the mothers and fathers to intervene with their children in preventing violence (Crooks, Goodall, Baker & Hughes, 2006). Behavioural skills and motivation are the most critical determinants, and these two are independent of behaviour change. Motivation and information can directly affect behaviour when behavioural skills are familiar or uncomplicated (WHO, 2018). The model has been proven to be effective, and the application of its constructs has accounted for an average of 33% of the variance in behaviour change (WHO, 2018). The health-promoting behaviours this study focused on were those likely to empower women to cope with, reduce and prevent IPV from occurring within their homes.

7.2.2 Information-Motivation-Behavioural Skills model IMB Constructs Information

Accurate information about a problem is an essential building block in supporting individuals' transitions to healthy behaviour choices (Fisher & Fisher 2006). The author says that facts about endorsing specific behaviour, heuristics concerning the behaviour, and implied assumptions concerning the behaviour are captured together with preventative information (Fisher & Fisher 2006). In this context, information about basic knowledge about IPV as outlined in the Domestic Violence Act, South African Constitution, and Chapter 2 of the Constitution (Bill of Rights) was assessed using a questionnaire on a representative sample. The findings of the study are as follows:

- Most of the IPV victims (87%) were financially dependent on men because they were not educated to be formally employed. They relied on child grants to supplement their partners' meagre income.
- Confirmation of widespread IPV in the district being studied, and most women had adequate knowledge of such forms of violence.
- The leading cause of IPV was alcohol and drug abuse by the partners or ex-partners who took these substances in excess to get the courage to confront their victims. 65% of the IPV victims indicated that their intoxicated male partners abused them on several occasions.
- What is culturally tolerable in one society can be considered abusive by others outside the culture. Corrective measures to address the situation are needed to stop IPV.
- From these findings, it could be concluded that women can be subjected to IPV regardless of their economic status as men show their violent behaviour toward submissive victims or those who reject men's dominance.
- The findings indicate that IPV was driven by *jealousy and low self-esteem among male perpetrators who wanted* total control of the IPV victims.
- Finally, the study found that the adverse influence of IPV intimate partners from relatives and friends was another factor that accounted for the violence between partners in an intimate relationship. Findings from the quantitative phase show that close to 70% of the respondents believe that family members and friends badly influenced their intimate partners.
- The study found that respondents and participants had preferred strategies, namely empowering women, reducing poverty in local communities, reducing alcohol and drug abuse, and including traditional leaders in reducing societal norms of violence.

7.2.2.1 Motivational attitude construct of the IMB model

The second construct within the model, preventative motivation, incorporates personal and social motivation. *Personal motivation* refers to a person's positive and negative attitudes toward partaking in health-promoting behaviours. This study encompassed personal attitudes towards avoiding IPV occurrences in the home, perceived social support for such behaviour, and the woman's subjective norm or perception of how other women who are IPV victims behave.

7.2.2.2 Behaviour skill construct of the IMB model

The IMB model stipulates that a highly informed and motivated person requires the appropriate behavioural skills to engage in health-promoting behaviours properly. These behavioural skills included a person's capability and self-efficacy in performing the skills. In this study, behavioural skills include ensuring that the woman has specific behavioural tools or strategies necessary to prevent IPV, such as self-regulating strategies and enlisting social support. These include (a) *placating*: attempts to change the abuser's behaviour without challenging him; (b) *resistance*: efforts that directly challenge the abuser's behaviour; (c) *safety planning*: strategies to increase the woman's resources or options for escaping or protecting herself; (d) *legal*: seeking help from the legal system; (e) *formal network* (nine items): accessing external resources other than legal help, such as health or religious services; and (f) *informal network* (four items): seeking advice or support from family members or friends to increase the woman's options and resources (Goodman et al., 2003).

7.3 Developed strategies to empower women against IPV occurrences

The developed strategies to empower women against IPV occurrences were divided into preventive, community-based, corrective and law enforcement (PreCCL). Table 7.1 shows the PreCCL strategies to empower women against IPV occurrences.

7.3.1 Preventive measures

- i. Introduce the syllabus with IPV lessons at the foundation phase to equip both girls and boys on knowledge and preventative measures of IPV;
- ii. Treating both girls and boys the same way prevents the patriarchal issues where the boys feel more superior to girls;

- iii. Each school should have a full-time or visiting school health promoter who will help in the identification of boys who are growing up or who grew up in abusive homes so that they can be assisted;
- iv. Most of the special days are for women, and men are excluded. Men and women should be treated equally, and both should be part of special days, which will benefit them in gathering knowledge of good behaviour.
- v. Financial management skills should be taught to couples by financial managers and financial empowerment of female victims and potential victims.

7.3.2 Community-based strategies / Home-grown strategies

- i. Focusing on both the abused and the abuser: Available services focus primarily on the victim; however, the suggested strategies require that both the abuser and the victim undergo counselling sessions by the VEPC therapist. The abuser must be persuaded to attend anger management programs offered by experts to equip him with the knowledge of the causes, harm, consequences, and preventative measures of IPV. Similarly, it was suggested that many NGOs and NPOs that assist the victims need to do so with abusers by increasing the manpower for such purpose. Counselling abusers in the presence of the victims may assist the former in changing their abusive behaviour and starting to respect and love their partners. Community-based strategies should encourage men to open up and get assistance to stop alcohol and drug abuse to create safe spaces for their partners and children. Counselling for abusive men can require them to be involved in care work so that they learn to be patient and tolerate views from women.
- ii. Suggested intervention strategies encourage women to open up about abuse, report it, and be taught to stand up for themselves against an abusive intimate partner.
- iii. It is suggested that women be economically empowered to be independent of men so that they can financially support themselves. This can be achieved by giving women more formal and informal employment opportunities. Formal employment involves absorbing women into the labour market in low-paying and high-paying jobs depending on their qualifications, giving them the same rights as men. Informal employment requires women to be involved in meaningful projects where they generate their income, unlike those reported in the study where women are saddled with loans from banks they will have to repay. Women need to be taught how to manage their finances

generated from the projects and their energy channelled away from those activities that make them see themselves as beauty queens or sex objects.

- iv. Unemployment should be addressed by creating jobs within different sectors to cater for those without formal qualifications. Instead of giving them R350 grants, unemployed men who abuse women due to financial challenges need to be involved in money-generating projects. Furthermore, much should be done to teach men how to stop misusing the grant money of the R350 monthly COVID-19 Grant Fund, which some spend on alcohol and drugs, the cause of high incidences of IPV. Employment will keep the men busy at their place of work instead of roaming around during the day in shebeens and beerhalls.
- v. Outreach programs in the communities target the abusers more than the victims. A lot has been done to educate women on IPV, and the quantitative study results confirm that most women had adequate knowledge of such forms of violence.
- vi. Marriage counsellors provide counselling before marriage and intra-marriages. Faith-based organisations, traditional leaders, and civic organisations assist the victims and perpetrators in getting solutions to marital problems. Neighbours and community members should be encouraged to report the acts of IPV to relevant services available in such communities.
- vii. Pocket-sized cards with information on available services should be made available. Every woman should carry a card with several services available nationally and locally. This can help women know who to contact in the case of IPV.

7.3.3 Corrective Measures

- i. Affordable safe homes for victimised women should be available to support them during counselling.
- ii. The perennial problems of alcohol and drug abuse should be addressed. Most victims reported being abused whilst their partners were under the influence of drugs and/or alcohol. Men abusing alcohol and/or drugs should be rehabilitated until they are free from addiction. Men are encouraged to consume alcohol responsibly.

				<p>Awareness and campaigns at taxi/bus ranks, malls, churches, and community meetings.</p> <p>Improving the upbringing of the young boys so that they should not resort to violence\</p> <p>negotiation</p> <p>imposition</p> <p>Community-based strategy</p> <p>Involve men and women in the programs addressing IPV issues.</p> <p>Boychild to be taught how to treat a girlchild.</p> <p>Pocket size card with information on available services against IPV</p>	Quantitative Checklist
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7.4 Validation of PreCCL strategies for IPV management

This phase was designed to validate PreCCL strategies to empower women against IPV occurrences. In this study, the PreCCL strategies were validated by a panel of experts, mainly the managers who knew the district's IPV issues. As detailed in Chapter 3 of this study, all ethical protocols were observed. The rationale for validating the PreCCL strategies was explained to obtain stakeholder buy-in and to ensure that the developed intervention strategies may be accepted and implemented. The target population was managers from Vhembe TVEP, members of the Executive Council and the Chairperson of gender equity, disability, women, and children of the 6th administration of Limpopo provincial Legislatures, heads of departments or directors from the Departments of Health, Social Development and Community Safety, and Security, Chairperson of gender equity, TVEP managers, as well as women who were victims from Vhembe. The sample size was 38 experts. The setting for the PreCCL strategies validation was Vhembe District Tshifulanani at Munnandinnyi and Hadumasi, the Victorious Community offices, but due to COVID-19 regulations, other stakeholders failed to attend, and the forms were emailed to them together with the PreCCL strategies. The researcher provided the experts with a summary of the study findings and the developed intervention strategies.

The researcher developed a checklist with 15 closed-ended questions, and participants were asked to rate each strategy on a given Likert scale. Participants were also given space to comment on the relevance, acceptability and possibility of implementing the strategies (see Appendix 11). The checklist and list of strategies developed were sent to stakeholders through emails for completion and commenting. A few comments from the experts were analysed and used to improve the strategies accordingly. The data were analysed quantitatively using SPSS. Of the 65 questionnaires sent, only 38 were completed on time. The response rate was 58.5%. The reliability of the validating questionnaire measured on the Cronbach Alpha was 0.67, which was acceptable for this study.

7.5.1 Demographic information for validating stakeholders

Demographic information of validating stakeholders is presented in Table 7.2.

Table 7.2: Demographic information of validating stakeholders

n = 38		
Gender	Frequency	Per cent
F	24	63,2
M	14	36,8
Total	38	100,0
Age range	Frequency	Per cent
20 to 30	8	21,1
31 to 40	12	31,6
41 to 50	10	26,3
Over 50	8	21,1
Total	38	100,0
Level of education (n = 38)		
Educational Level	Frequency	Per cent
Certificate	5	13,2
Diploma	15	39,5
Bachelor's degree	12	31,6
Honour's Degree	3	7,9
Master's degree	3	7,9
Total	38	100,0
Marital Status (n =38)		

Marital status	Frequency	Per cent
Single	9	23,7
Cohabiting	3	7,9
Married	14	36,8
Separated	3	7,9
Divorcee	9	23,7
Total	38	100,0

The majority of the validating stakeholders (n = 24; 63,2%) were females and the minority (n =14; 36.8%) were male. The results further show that most (n = 22; 56,9%) were aged between 31 and 50 years, while the minority (n =8; 21.1%) were below 20 years and over 50 years, respectively. The average age was 34,9 years. The results show that educational levels of the stakeholders was fairly high as it varied from certificate to master's degree, with certificate (n = 5; 13.2%), diploma (n = 15; 39.5%), Bachelor's degree (n = 12; 31.6%), honours' and master's degrees (n =3; 7.9%) apiece. There was a fair distribution among the reviewers' marital status: single (n =9; 23.7%), married (n = 14; 36.8%) and divorced (n =9; 23.7%). This implied that the views from married validating stakeholders dominated slightly over those of other marital statuses.

The results in Table 7.3 show the ratings of each validation item, the mean, and the standard deviation. A mean greater than 3.4 shows that validating stakeholders tended to agree with the notion expressed in the validation item.

Table 7.3: Results of the validation of PreCCL strategies

	Validation statement	SA	A	NS	DA	A	Mea n	SD
		n (%)	n (%)	n (%)	n (%)	n (%)		
1.	The purpose of the strategies goal is clearly stated	7 (18,5)	25 (65,8)	0 (0)	6 (15,8)	0 (0)	3,9	0,9
2.	The strategies are easy to understand	9 (23,7)	25 (65,8)	0 (0)	4 (10,6)	0 (0)	4,0	0,8
3.	There are no similarities among evaluation criteria in	11 (29)	20 (52,7)	0 (0)	7 (18,5)	0 (0)	3,9	1,0

	Validation statement	SA	A	NS	DA	A	Mean	SD
		n (%)	n (%)	n (%)	n (%)	n (%)		
	different components of strategies							
4.	The sequencing of the strategies is acceptable	7 (18,5)	26 (68,5)	2 (5,3)	6 (15,8)	0 (0)	3,8	0,9
5.	The strategies are easy to implement within the communities	4 (10,6)	28 (73,7)	1 (2,7)	5 (13,2)	0 (0)	3,8	0,8
6.	The strategies are inclusive of victims and perpetrators	9 (23,7)	23 (60,6)	0 (0)	2 (5,3)	0 (0)	3,9	0,9
7.	The strategies reflect the ideas of the participants	4 (10,6)	31 (81,6)	0 (0)	3 (7,8)	0 (0)	4,0	0,7
8.	The strategies are gender-transformative	3 (7,9)	26 (68,5)	6 (15,8)	3 (7,9)	0 (0)	3,8	0,7
9.	The strategies address IPV preventive methods in the community	7 (18,4)	26 (68,4)	0 (0,0)	5 (13,2)	0 (0)	3,9	0,9
10.	The strategies have the potential to empower IPV victims	6(18,4)	26 (68,4)	0 (0)	5 (13,2)	0 (0)	3,9	0,9
11.	The strategies are gender-neutral	9 (23,7)	22 (57,8)	0 (0)	7 (18,5)	0 (0)	3,9	1,0
12.	The strategies are easily accessible to IPV and other community members	16 (42,2)	20 (52,7)	0 (0)	2 (5,3)	0 (0)	4,3	0,7

The results show that most validating stakeholders (n = 32; 84.3%) indicated that the purpose of the strategies' goal was clearly stated. The Mean \pm SD (3,9 \pm 0,9) validates that the stakeholders agreed with the clarity of the purpose of the strategies. This implied that users

would be able to interpret and understand the purpose of the developed strategies in alleviating IPV in the district. The strategies were viewed as being easy to understand by most ($n = 34$; 89.5%; Mean \pm SD (4 ± 0.8) of the validating stakeholders ($n = 9$; 23.7% strongly agreeing and $n = 25$; 65.8% agreeing) with the minority ($n = 4$; 10.5%) indicating otherwise. These results indicate that the strategies required little effort from the implementer to understand. Another objective of validating the strategies was to determine that there were no similarities among the strategies. The absence of similarity was confirmed by most ($n = 31$; 81.7%) of the respondents, while a few ($n = 7$; 18.5%) confirmed the presence of similarity among statements. The statistical Mean \pm SD (3.9 ± 1) values that the validating stakeholders agreed with but with a wide variation in their ratings. Due to these variations, those strategies regarded as being similar were rephrased to remove duplications. This was done with the assistance of the reviewers. The sequencing of the strategies was found to be acceptable, as indicated by most of the respondents ($n = 33$; 87.9%) who agreed and the minority ($n = 6$; 15.8%) who disagreed. The Mean \pm SD (3.8 ± 0.9) confirm that the strategies were accepted as being well sequenced.

The implementation of strategies by community members and stakeholders was found to be appreciably easy, as indicated by most of the respondents ($n = 32$; 84.3%) and confirmed by the Mean \pm SD (3.8 ± 0.8). These results show that reviewers believed that most people in the communities could easily implement the strategies to reduce IPV. In order to address IPV effectively, strategies were supposed to be inclusive of both victims and perpetrators. The results of the rating for this item show that the majority of the respondents ($n = 32$; 84.3%) were convinced that these strategies included both the victims and the perpetrators. This was reflected by the Mean \pm SD (3.9 ± 0.9), which much agreed with little difference among the respondents. Validating stakeholders were asked to validate whether strategies reflected the ideas expressed by participants. Results show that most respondents ($n = 35$; 92.6%) and the Mean \pm SD (4.0 ± 0.9) affirmed that the strategies reflected the participants' views. This finding shows that the strategies were homegrown and addressed IPV issues in the communities being studied. Most of the validating stakeholders ($n = 33$; 86.8%) and the Mean \pm SD (3.9 ± 0.9) confirmed that the strategies were regarded as addressing IPV preventive methods in the community from which participants were drawn. Concerning empowering IPV victims, most of the reviewers ($n = 33$; 84.8%) indicated that strategies could assist victims in many ways. The Mean \pm SD (3.9 ± 0.9) further confirmed the agreement by the validating stakeholders that all the strategies were designed to address the empowerment of women against IPV in rural communities. On gender-neutrality, most respondents ($n = 31$; 81.5%)

indicated that strategies were gender-neutral in addressing IPV while placing responsibilities on both women and men. The Mean \pm SD (3,9 \pm 1.0) indicated that validating stakeholders rated the strategies as gender-neutral variedly. This implied that implementing gender-neutral strategies would be inclusive in addressing IPV in the communities. Most respondents rated the accessibility of strategies to IPV and other community members as very good (n =26; 94.9%) with a Mean \pm SD (4.3 \pm 0.7). This implied that members of the community were able to understand the strategies and would be able to implement them in solving IPV problems within partners before seeking external assistance.

Relevance of strategies: The relevance of the strategies in solving the IPV problem was reviewed using a 4 – point Likert scale Very relevant (VR =4); Relevant (R = 3); Just relevant (JR =2), and Not relevant (NR =1). The results of the relevance of the strategies are shown in Table 7.4.

Table 7. 4: Relevance of the PreCCL strategies

	Validation statement	VR	R	JR	NR	Mean	SD
		n (%)	n (%)	n (%)	n (%)		
3.	How relevant are the strategies to the types of IPV problems being involved?	6 (15,8)	30 (78,9)	0 (0)	2 (5,3)	3,0	0,7

The strategies were rated as being relevant in addressing IPV in the district by most of the reviewers (n = 36; 97,4%; Mean \pm SD = 3.0 \pm 0.7), in which 15.8% (n= 6) strongly agreed and 78,9% (n =30) agreed.

The importance of strategies in addressing IPV in the communities was validated based on *Very important* (VI = 4), *Important* (I =3), *Not sure* (NS = 2), and *Not Important* (NI = 1), as shown in Table 7.5:

Table 7:5: Importance of strategies

	Validation statement	VI	I	NS	NI	Mean	SD
		n (%)	n (%)	n (%)	n (%)		
14.	How important are these strategies in addressing IPV in your community?	7 (18,5)	25 (65,8)	0 (0)	5 (13,3)	3,8	1,2

These results by most respondents (n = 32; 84.3%) and Mean ± SD (3.8 ±1.2) show that the strategies were regarded as very important in addressing IPV in the communities. Only a minority of the validating stakeholders (n = 5; 13.2%) indicated that the strategies were important in solving IPV problems in the district.

The strategies were further validated on their potential effectiveness using a 4 – point Likert scale: Very effective (VE = 4); Effective (E = 3); Not sure (NS = 2) and Not Effective (NE = 1)”. Results are in Table 7.6.

Table 7. 6: Effectiveness of the PreCCL strategies to address IPV

	Validation statement	VE	E	NS	NE	Mean	SD
		n (%)	n (%)	n (%)	n (%)		
15.	How effective do you think the strategies will address IPV in the community?	10 (26,3)	24 (63,2)	0 (0)	4 (10,5)	3,2	0,6

The strategies were validated as being effective in addressing IPV by most of the reviewers (n =34; 89.5%) and were confirmed by the Mean ± SD (3.2 ± 0.6). The overall validation for the *relevance* of the strategies was done on a 4-point Likert scale (*Relevant as they are* = 4; *Relevant with minor improvement*= 3; *Relevant with major improvement* = 2; *and strategies not relevant* = 1). Figure 7.1 depicts the results of relevance validation.

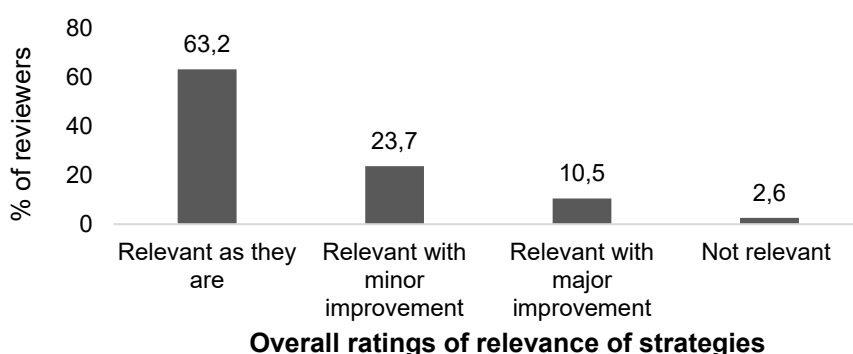


Figure 7.1: Overall ratings of the relevance of PreCCL strategies

The overall rating of the strategies shows that most (n = 24; 63.2%) of the validating stakeholders believed that strategies were relevant, and 9 (23,7%) thought the strategies were

relevant but needed minor improvement. 10,5% (n = 4) of the validating stakeholders indicated that strategies were relevant but needed a major improvement and only 1 (2.6%) of the respondents thought the strategies were irrelevant.

The overall validation for *acceptance* and relevance of the strategies was done on a 4-point Likert scale (*Strategies acceptable as they are* = 4; *strategies acceptable with minor improvements* = 3; *strategies acceptable with major improvements* = 2; and *strategies not acceptable* = 1). Figure 7.2 shows the results for validating stakeholders' acceptance of the strategies.

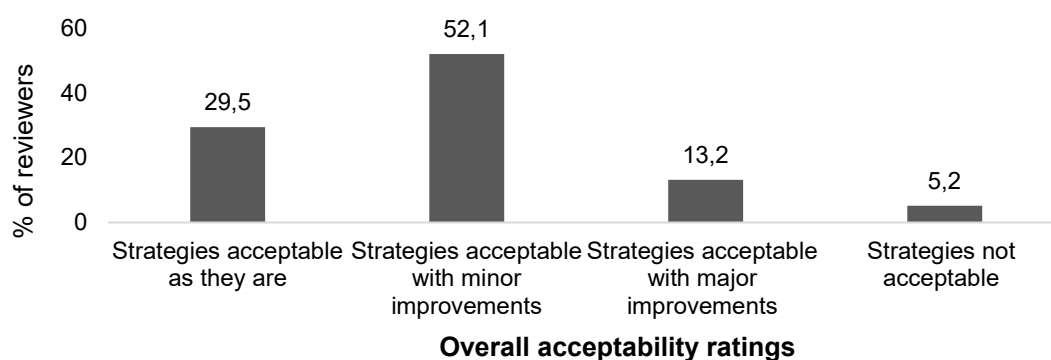


Figure 7.2: Rating of the acceptability of PreCCL strategies

The results displayed in figure 7.2 indicate that 11 (29,5%) validating stakeholders indicated that strategies were acceptable as they were, 20 (52,1%) acceptable with minor improvements, 5 (13,2%) indicated acceptable with major improvements, and only the minority 2 (5.2%) indicated not acceptable. The Mean \pm SD (3.7 \pm 0.6) confirm that the strategies were accessible with or without recommended changes. Validating stakeholders were asked to indicate whether the developed strategies can be recommended to address IPV in the affected communities. The results in Table 7.6 shows how the validating stakeholders responded.

Table 7.6: Recommendation of the use of the PreCCL strategies

Item	Response choice (n =38)						Total	
	Yes		Not sure		No			
	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)
Would you recommend using the PreCCL strategies to address the IPV problem in the Vhembe District in this form?	34	89,2	1	2,6	2	5,2	38	100

The depicted results show that the majority of the validating stakeholders (n = 34; 89.6%) recommended adopting the developed strategies in the current form. The minority (n = 1; 2.6%) were not sure, and (n = 2; 5.2%) did not recommend adopting the developed strategies in this form. The validation process was completed, and the findings show that the PreCCL strategies were relevant and acceptable as they were recommended for adoption by most of the validating stakeholders.

7.6 Implementation and evaluation of the developed strategies

Implementation and evaluation of the implemented strategy are beyond the scope of this study. However, the researcher intends to implement the developed strategies in rural areas where the study was conducted. The PreCCL strategies will be rolled out at a smaller scale, where community health workers will be trained for five days in each district to implement the strategies. The buy-ins from the Department of Social Services, the custodian of the strategy, will be sought first. During the implementation stage, the researcher will ensure that the PreCCL strategy has the support of TVEP managers and is aligned with the department's policies. The strategies will then be evaluated to ascertain their impact at the community level. An evaluation method will be selected, and the tool will be developed and utilised with the group of IPV experts and IPV victims. During the evaluation process, the researcher will assess the feasibility and acceptability of the strategies. The researcher will also evaluate the PreCCL strategy outcome.

7.7 Improvement of developed strategies

After validating the developed strategies, recommendations were made, resulting in the following representations. Different strategies have been recalibrated and illustrated in different figures. Figure 7.3 shows the interrelatedness of the categories of strategies emanating from the study and recommendations from reviewers. Each set of strategies has a bearing on the other sets and needs to supplement each other. It is important to note that overlaps in strategies are highly possible. The actors in each case need to be aware of what strategies are being used to address IPV by the other group to avoid unnecessary overemphasis that could dilute the effectiveness of the strategies. The communities, families, IPV victims, abusers, social welfare and legal structures are important players in formulating and applying strategies to reduce and eradicate IPV. Inclusive strategies call for the inclusion

of IPV perpetrators to provide an awareness of the effects of their violent behaviour. Each category of strategies is illustrated in separate figures accompanied by an explanation.

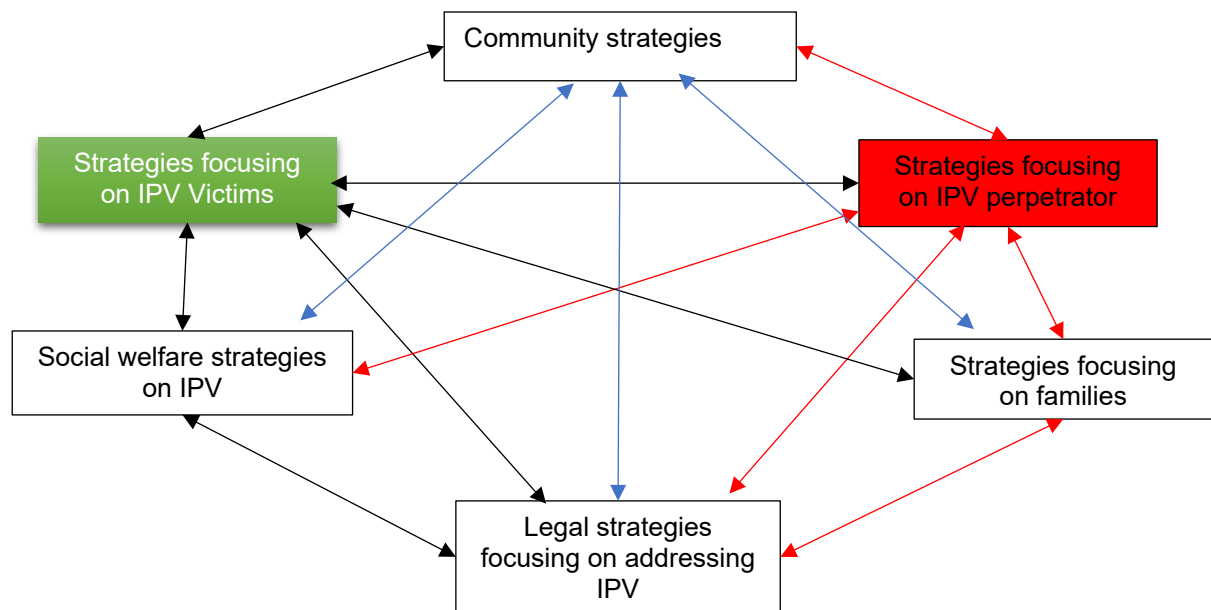


Figure 7.3 Shows strategies focusing on families in addressing and redressing IPV

Strategies focusing on the community: This study found that the community plays a vital role in escalating or reducing IPV issues. Everyone belongs to a community, and the community can influence an individual because it functions as a unity. Therefore, it was important to involve the community in IPV matters so that every community member becomes aware of the pandemic and works towards reducing it. Figure 7.4 shows the strategies in the community category. Most of the components of community-based strategies seek to address IPV at a higher level where the village elders and church leaders are involved. Such strategies use persuasion and diplomacy but can use other decisive methods, including sanctions such as fines, apologies, community punishment, and even excommunicating offenders. Communities have some effective methods of dealing with IPV when appropriately applied. Having women protected against violent men requires the village elders to be strict and use the existing laws and traditional ways of sanctioning wayward men. Persistent perpetrators of IPV can be deprived of some of the privileges the community affords them.



Figure 7.4: Strategies focusing on the community

Strategies focusing on the families: After the community comes the family, which plays an important role in the upbringing of children. There is a need for family strategies to address IPV in the district. Figure 7.5 illustrates the strategies for the family. These strategies place the family at the centre of all activities that may lead to IPV. Abusive men belong to families where women play an important role in family traditions. Strategies seeking to empower women should address reducing IPV against women in the communities and should, therefore, start at the family level. Most men respect their mothers, fathers and probably siblings. This implies that the strategies dealing with IPV should include the family instead of focusing on the abuser. This study recognises the importance of the family in initiating IPV reduction activities in which men play an active role as heads of families. However, challenges may arise where the abuser is from a broken family; hence, some strategies must be considered. Community-based strategies are essential when the family fails to deal with perennial IPV in which the abuser disrespects those close to him. Figure 7.5 shows family-based strategies resulting from the findings of the study.



Figure 7.5: Strategies focusing on the families

Strategies for empowering women: Some strategies suggested focusing on empowering women to deal with IPV in some cases. Figure 7.6 shows suggested strategies. Strategies focusing on empowering women require IPV victims and other women to be actively involved in dealing with the pandemic. Conflict and anger management among IPV victims is important. In some instances, the study found that some women reported having short tempers dealing with abusers of the same characteristics. Anger management means that victims can think about what to do carefully before being victimised repeatedly. This means pretending to placate and defend oneself against abusers. Because some IPV is related to women's economic dependence on men, IPV victims in a community can come together to form projects within their means and seek assistance from the village elders and local health personnel. Women need the right information to make correct decisions, which can be obtained from relevant structures in the community. However, education is integral to achieving a certain degree of information management. Poor education can lead to a lack of understanding of given information which is always wrongly interpreted to the detriment of the victims. Empowered women can evaluate the situation in which they find themselves and try to

negotiate their way out. This has been found lacking among most victims as they lacked education and acted impulsively due to poor assessment of the situation. In some cases where women were supposed to report, they kept quiet after being sweet-talked by abusers. IPV victims need to have easy ways of reporting incidences of abuse without being threatened by those to whom they report. They need to be protected from being shamed by other community members so that they dare to expose all forms of IPV. Involving women in projects for economic empowerment is paramount to solving IPV.



Figure 7.6: Strategies for empowering women

Strategies focusing on abusers: Similar to the IPV victims, abusers typically suffer from empowerment deficiencies which make them hostile towards women. See Figure 7.7 below for strategies to empower IPV perpetrators to compensate for this weakness. Deficiencies in some men lead to toxic relationships with unsuspecting women whom they end up abusing. Therefore, these men need to be empowered to overcome either inferiority or superiority complexes which affect their relationships with female IPs. Figure 7.7 illustrates suggested strategies from the study to address issues with violent male IPs. Unempowered men tend to be dominant, unable to manage conflict and anger, and are therefore intolerant of other views differing from theirs. These are traits that can be changed by programmes tailored to empower

such IPs who think that problems can be solved by violence against women. From the findings of the study, it was shown that intolerant men tended to be irresponsible with their bad habits. Therefore, it suggested that there should be strategies to educate men to be accountable for their bad behaviour towards women. By doing this, it would be the responsibility of men to live with women peacefully and protect them against abusers from somewhere else. Lack of respect and distrust of women is something learned from tradition, and men need to be taught to dissociate themselves from such tendencies and adopt modern ways of living peacefully with women. Furthermore, the strategies seek to instil a sense of responsibility towards good traditional practices and the laws of the country.



Figure 7.7: Strategies focusing on men

Suggested legal strategies: Where some soft strategies fail, hard ones need to be used, especially legal ones. Figure 7.8 shows suggested legal strategies that can be of use in addition to the existing ones. IPV victims face the laxity of the South African legal framework, which gives equal rights to the abuser and the abused. In some cases, the abused fear approaching the police due to hopelessness. This suggested a few strategies that may supplement the existing legal ones. Policing areas with a high prevalence of IPV or perpetrators of IPV is needed to root out this pandemic. This implies that the police can work with the public to sniff out even the smallest IPV or gender-based violence. There is also a need to have police personnel trained in this area to understand the trauma and stress that IPV victims undergo. Our findings suggest that most IPV victims are not familiar with South African law beyond having rights. For this reason, this study has proposed that women need to be educated about the legal system so that when they report cases, they can always understand what to do when confronted with situations at police stations. IPV victims who are unfamiliar with the laws usually give up when the police take the time to open cases against IPV perpetrators. IPV victims need protection from the perpetrators and/or families or friends of perpetrators who threaten them with consequences of high magnitude if the perpetrator is

jailed. This leads to IPV victims either not reporting or withdrawing charges. This malpractice needs to be addressed by providing women with adequate legal education.



Figure 7.8: Suggested legal strategies

In many cases, perpetrators on parole or bail inflict much fear on IPV victims. Our strategies recognise the need to deny these offenders bail or reduced sentences as they come and cause unbearable suffering to the victims who can commit suicide or harm others. If some members of the families were aware of the IPV being perpetrated and had not taken action to report it, legal action should be brought against such people. Furthermore, the strategies seek redress in the form of compensation by the IPV perpetrators for any suffering endured by the victims, and the courts should seek to enforce this. Finally, in South Africa, most IPV cases drag on for a long time without recourse to the pain caused to the victim; therefore, strategies seeking a speedy trial of perpetrators were included. The victims should not be troubled in travelling up and down to courts, culminating with the perpetrator being released.

Strategies on Social Welfare: Social Welfare can provide social workers who work in the communities with healthcare workers. They can identify IPV victims and perpetrators in the communities they work in and recommend support such as counselling. Social workers can

also provide IPV education and counselling to the public in general and individuals affected. Figure 7.9 shows the strategies focusing on social workers.



Figure 7.9: Strategies focusing on social welfare structures

7.8 Conclusion

In this chapter, the researcher developed PreCCL strategies through a stakeholder workshop, and it was guided by the IMB behavioural model of social change. The researcher identified strategies that the victims used and developed home-based and community-based strategies to ultimately reduce the occurrence of IPV by promoting healthy relationships free from violence and full of respect. Intervention strategies were developed through a stakeholders' workshop. Stakeholders were requested to identify intervention strategies in addition to the suggested strategies to empower women against IPV occurrences by improving current conventional strategies to home or community-based strategies. The strategies were quantitatively validated using data from expert validating stakeholders. The findings were that validating stakeholders positively validated all strategy items as being relevant to addressing IPV problems in the district. According to the results, developed strategies were accepted with a few minor recommendations at the researcher's discretion. Validating stakeholders overwhelmingly recommended the adoption and use of the IPV strategies. The next chapter

provides the conclusion and recommendation for the study and includes the highlights of the study objectives and research questions.

CHAPTER 8

OVERVIEW, CONCLUSIONS, CONTRIBUTIONS AND LIMITATIONS

8.1 Introduction

The previous chapter described the development of IPV strategies and their validation in terms of relevance and acceptability by experts from the district. This chapter provides five important aspects of the study, namely, the overview of the study, conclusions, contributions, limitations, and recommendations for further research.

8.2 Overview of study

This study aimed to develop home-grown strategies to address IPV problems faced by women in the Limpopo province, the unit of study being the Vhembe District. The study was organised into two major phases: Phase 1 was developing the research agenda, needs analysis and empirical study, and Phase 2 was developing and validating the strategies. Phase 1 was subdivided into Phase 1a, Quantitative and Phase 1b, Qualitative. Three objectives were set for the Quantitative phase:

- To measure the level of general knowledge regarding intimate partner violence among IPV victims in the Vhembe district.
- To describe the victim's motivational attitude towards the acquired IPV information to act against any form of IPV behaviour in the Vhembe district.
- To assess the behavioural skills used by victims in dealing with any IPV occurrence.

The qualitative phase depended on the findings of the quantitative phase. The study was organised into eight chapters, as summarised in Figure 8.1.

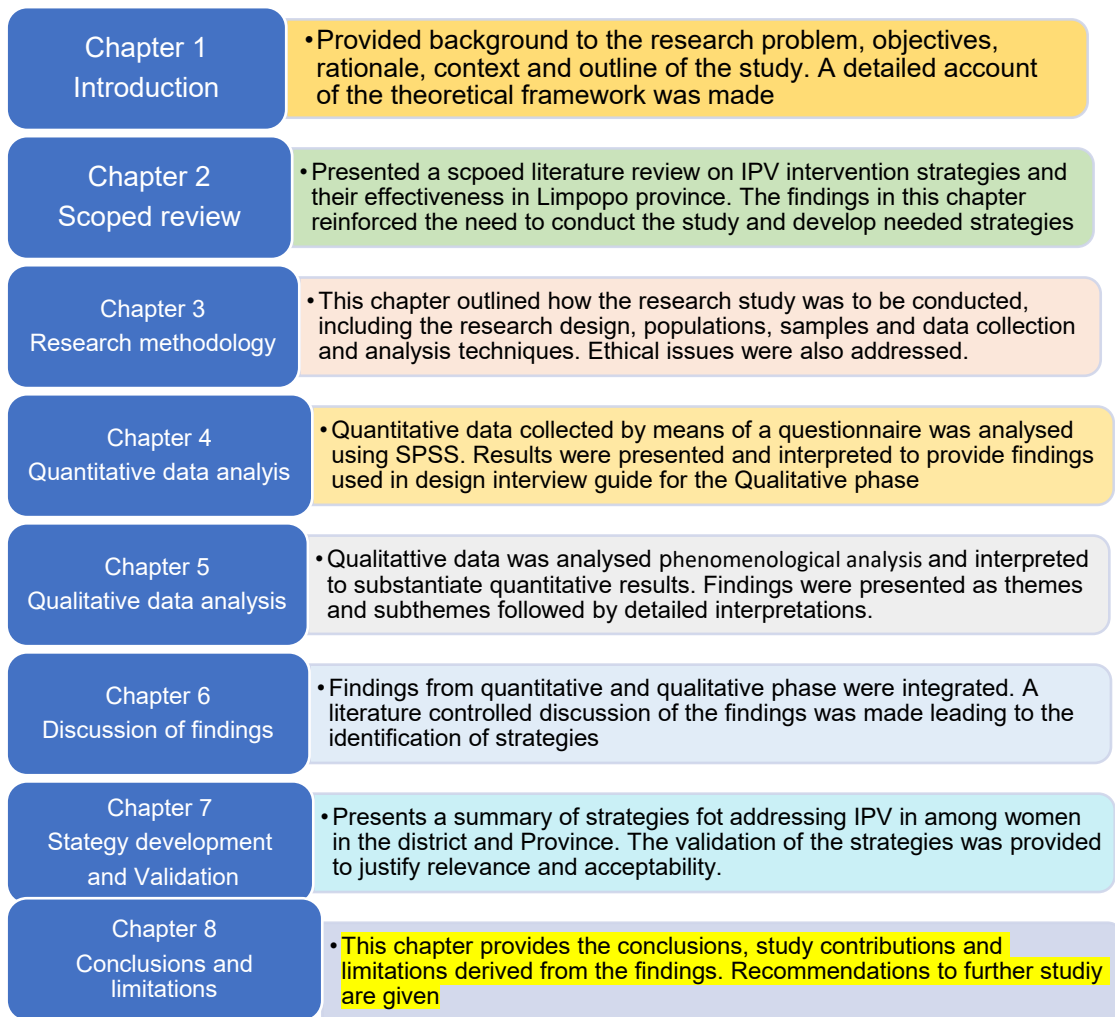


Figure 8.1: Overview of the study.

8.3 Conclusions

Several conclusions emanated from the findings of the study. Starting with the scoping review, the study concluded that:

- a. The IPV interventions used in Limpopo province were a hybrid of community-based, legal and policy-oriented. These involved using strategies to alleviate poverty in rural areas through economic empowerment such as the IMAGE, gender-transformative strategies and workshops targeting traditional leaders.
- b. Most of the IPV interventions were imposed on the communities and had short-term life effects after the withdrawal of support.
- c. Legal and protection orders were pro-IPV perpetrators who utilised loopholes in the system. IPV victims still lived in fear even after the protection orders, as the perpetrators violated these orders repeatedly because most of the family members

continued to victimise the women without any punitive measures. Although aware of these transgressions, IPV victims also tended to withdraw cases to stop the prosecution of perpetrators due to fear of stigmatisation and further repercussions, which implies that these IPV interventions were ineffective.

- d. The level of awareness of IPV of victims in the Vhembe district was reasonably good due to previous campaigns, although victims and community members were not proactive in dealing decisively with the problems besides opening cases against the perpetrators.
- e. IPV victims rarely used existing support structures voluntarily and only after being compelled by relatives and neighbours due to fear of stigmatisation and mistrust of service providers who would divulge information about mishaps in relationships. Due to poverty and over-reliance on perpetrators' financial and material resources, most IPV victims were not empowered enough to stand up against perpetrators or leave the relationship.
- f. The most preferred IPV intervention strategies were the home-grown ones with direct involvement of perpetrators, relatives, traditional leaders, psychologists, counsellors, and stakeholders such as the police and legal practitioners.
- g. Strategies with practical application of gender equity involving men as key players were considered to be worthwhile.
- h. IPV victims and stakeholders were prepared to collaborate in fighting both GBV and IPV by participating in peaceful campaigns led by local community members rather than outsiders.
- i. The developed strategies are accepted on the strengths of their relevance and are easy to implement by ordinary people, including IPV victims. The developed strategies revealed that the fight against IPV and GBV was not only the problem of victims but also the community.

8.4 Contributions to the body of knowledge

The contribution of this study was three-fold, namely:

- a. It revealed the state of IPV interventions in Limpopo and their ineffectiveness in addressing the persistent IPV problems in the communities. After conducting a scoping review, the study demonstrated that the IPV challenges were being addressed using strategies incompatible with the local communities or excluding perpetrators or men. Most of the interventions were projects or experiments conducted to check their effectiveness and lasted for a shorter time frame.

- b. It developed home-grown and inclusive PreCCL strategies based on practical and feasible solutions suggested by members of the local communities. The developed strategies have been validated as relevant to the existing IPV challenges and accepted for implementation by local communities with minimum assistance and supervision or the use of legal coercion. By developing these strategies, the study contributed to knowledge in this field as both practitioners and those interested in solving IPV problems will have an additional source to reference or use.
- c. This study contributed to the literature on home-grown IPV strategies for the Limpopo province, particularly in rural communities. Literature has been scarce on home-grown IPV strategies conducted in Limpopo. The completion of this study will go a long way to provide researchers and practitioners to reconsider the importance of solving IPV challenges using home-grown solutions. The study will likely form the basis for more studies in this field to challenge the status quo in other communities.

8.5 Limitations

The generalisation of this study to situations outside Limpopo may have been constrained by the conditions under which the study was conducted. The collection of data for validation was affected by the COVID-19 regulations, which caused the researcher to deviate from the standard practice of focus groups with IPV victims. Online strategies could not be used due to the poor connectivity of participants. The small sample used in the validation of the study could make it difficult to generalise the study to the whole Limpopo population. Another limitation was the dimension of the study, which focused on women only. Issues of IPV consider male partners. Including male partners in the victimisation of female partners could have collected rich and diverse data for developing strategies that address both sides of the story. Although this study could be significant for the communities and academia, the absence of the voice of male or IPV perpetrators on IPV issues leaves a grey area that still needs further investigation. By targeting only adult IPV victims, this study left out adolescents and teens likely to fall into the same challenges.

8.6 Recommendations

The following recommendations are made: The recommendations are referred to the three departments of the Limpopo Provincial Government and VEP centres in the Vhembe district.

Government departments:

- Department of Health, Social Welfare, Safety, Community Services, and Justice to adopt and implement the developed intervention strategy and engage NGOs, NPOs, faith-based organisations and other stakeholders for support to roll it over in one sub-district to assess its effectiveness.
- The concerned departments must ensure that they review the counselling materials and confirm that facilities offer support to perpetrators and victims.

Policymakers:

- Develop guidelines that encourage the communities and family members to form part of the teams fighting against IPV occurrences.
- Develop an appropriate community-based or home-grown strategies

8.7 Further research

Further similar studies throughout the country are needed to increase data on developing intervention strategies to empower all women against IPV.

8.8 Plan for dissemination of research findings

The study findings were disseminated through the following means: a soft copy will be sent to the University of Venda library for future use, research findings will be published on the Department of Justice database, and a hard copy will be sent to the Vhembe Department of Justice and TVEP. The study findings will also be published in peer-reviewed journals and presented at conferences and workshops.

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APPENDICES

Appendix 1: Ethical clearance

ETHICS APPROVAL CERTIFICATE

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:

Ms. L Nethavhani

STUDENT NO:

11543306

PROJECT TITLE: Development of strategies to empower women against intimate partner violence occurrences in Vhembe district, Limpopo province.

PROJECT NO: SHS/20/PH/19/1109

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Dr T.G Tshitangano	University of Venda	Promoter
Dr N.S Mashau	University of Venda	Co - Promoter
Ms. L Nethavhani	University of Venda	Investigator – Student

Type: **Doctoral Research**

Risk: **Minimal risk to humans, animals or environment**

Approval Period: **September 2020 – September 2023**

The Human and Clinical Trials Research Ethics Committee (HCTREC) hereby approves your project as indicated above.

General Conditions

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following.

- The project leader (principal investigator) must report in the prescribed format to the REC:
 - Annually (or as otherwise requested) on the progress of the project, and upon completion of the project
 - Within 48hrs in case of any adverse event (or any matter that interrupts sound ethical principles) during the course of the project.
 - Annually a number of projects may be randomly selected for an external audit.
- The approval applies strictly to the protocol as stipulated in the application form. Would any changes to the protocol be deemed necessary during the course of the project, the project leader must apply for approval of these changes at the REC. Would there be deviated from the project protocol without the necessary approval of such changes, the ethics approval is immediately and automatically forfeited.
- The date of approval indicates the first date that the project may be started. Would the project have to continue after the expiry date; a new application must be made to the REC and new approval received before or on the expiry date.
- In the interest of ethical responsibility, the REC retains the right to:
 - Request access to any information or data at any time during the course or after completion of the project,
 - To ask further questions; Seek additional information; Requires further modification or monitor the conduct of your research or the informed consent process.
 - withdraw or postpone approval if:
 - Any unethical principles or practices of the project are revealed or suspected.
 - It becomes apparent that any relevant information was withheld from the REC or that information has been false or misrepresented.
 - The required annual report and reporting of adverse events was not done timely and accurately,
 - New institutional rules, national legislation or international conventions deem it necessary

ISSUED BY:

UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: August 2020

Name of the HCTREC Chairperson of the Committee: Pascal O. Bessong

Signature: 

Director Research and Innovation

Signature: *GIEE*kosse

15 September 2020

UNIVERSITY OF VENDA OFFICE OF THE DIRECTOR RESEARCH AND INNOVATION 2020-09-16 Private Bag X5050 Thohoyandou 0950

Appendix 2: Approval letter Nethavhani L ESHDC Proposal Approval letter
(2)_220227_191145



University of Venda

School of Health Sciences

Research Office

Executive School Higher Degree Committee

To : Ms L Nethavhani

Department of Public Health (PhDPH Candidate)

From : Prof RT Lebese

Research Professor, School of Health Sciences

Date : 04 August 2020

Decision of the Executive School Higher Degree Committee on 03 August 2020

Application for approval of a Thesis proposal report in Public Health: **L Nethavhani (11543306)**

Title: **Development of strategies to empower women against intimate partner violence occurrences in Vhembe District, Limpopo province.**

Promoter : Dr TG Tshitangano

Co-Promoter : Dr N MASHAU

ESHDC recommended for approval by the UHDC



Prof RT Lebese
Research professor (Chairperson of ESHDC)
School of Health Sciences

Appendix 3: Letter of Information

Title of the Research Study: *Development of strategies to empower women against IPV occurrences in Vhembe district, Limpopo province.*

Principal Investigator/s/ researcher: Nethavhani L, Master of Public Health

Co-Investigator/s/supervisor/s : Prof T.G Tshitangano

: Dr N.S Mashau

Brief Introduction and Purpose of the Study:

I am Nethavhani Lilian, a student studying for a Doctorate Degree in Public Health (PhD PH) at the University of Venda in Limpopo province and I am conducting a research study on the *development of strategies to empower women against IPV occurrences in Limpopo*, to develop strategies to empower women against intimate partner violence and I am asking people from your community to answer a few questions, which I hope will benefit you and your community and possibly other communities.

Outline of the Procedures: The researcher will be collecting data using questionnaires with close-ended questions

Risks or Discomforts to the Participant: no risks are anticipated.

Benefits: The researcher was expected to benefit academicall after completing doctorate degrees. The participants of the study were expected to benefit from articles and the published the research has been published, their plights might be heard. They may also benefit by completing the questionnaire, which will serve as a reminder of safety precautions at their workplace.

Reason/s why the Participant May Be Withdrawn from the Study: There will not be any adverse consequences if the participant wishes to withdraw from the study. Participants can withdraw if they no longer wish to be part of the study.

Remuneration: There will not be any monetary payment to participants for participating in this study.

Costs of the Study: Participants will not cover any of the study costs. The researcher will fund the study.

Confidentiality: Participants' names will be kept confidential, meaning that the researcher will not use participants' real names when handing out the questionnaires.

Research-related Injury: There are no research-related injuries anticipated. The researcher will withdraw from any interview if the participant feels they want to withdraw from the study.

Persons to Contact in the Event of Any Problems or Queries:

Please contact the researcher on 015 9628000, my supervisors Prof T.G Tshitangano and Dr N.S Mashau on 0824584689 or the University Research Ethics Committee Secretariat on 015 962 9058. Complaints can be reported to the Director: Research and Innovation, Prof GE Ekosse on 015 962 8313 or Georges Ivo.Ekosse@univen.ac.za

General:

Potential participants must be assured that participation is voluntary and the approximate number of participants to be included should be disclosed. A copy of the information letter should be issued to participants. The information letter and consent form must be translated and provided in the primary spoken language of the research population.

Appendix 4: Confidentiality Agreement

THIS AGREEMENT is made effective as of the 31 day of September, 2020

BY AND BETWEEN

Thohoyandou Victim Empowerment Program at 2, Old Embassy Buildings, Sibasa, 0970
(hereinafter referred to as the "Provider")

AND

(name) Nemauani Lillian at (address) Sibasa (hereinafter referred to as the "Recipient") WHEREAS the Provider is the owner or guardian of confidential material (hereinafter referred to as the "Confidential Material") which is not public knowledge;

AND WHEREAS it is acknowledged that this Confidential Material may take the form of electronic or hard copy data on any of the work undertaken by, for, or on behalf of NEP or any of their clients, employees, partners, stakeholders or other similar interested parties;

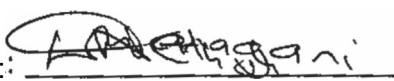
AND WHEREAS this confidential material is being disclosed to the Recipient only in so far that they may best perform their role and responsibilities to WEP;

AND WHEREAS this confidential material is only being disclosed to the Recipient under the terms and conditions of this Agreement;

THE RECIPIENT AGREES:

- 1.1 To uphold the strictest rules of integrity, ethics and responsibility about TVEP, its Clients and Confidential Material at all times;
- 1.2 To further take steps to safeguard the Confidential Material, ensuring it is collected, transported, stored and in general administered with respect and in line with established security measures; and
- 1.3 That the willful retention (for use other than strictly work-related), destruction, disclosure (including verbal), sale or similar activity of the Confidential Material is strictly prohibited and will result in instant dismissal (if the Recipient is an Employee/Volunteer/similar) or be punished to the full extent of the law (if the Recipient is not an Employee/Volunteer/similar).
- 1.4 That the Terms and Conditions of this Agreement have been fully explained to them.

SIGNED:

Recipient:  Date: 2020.09.28

Masikhwa T.

0

For or on behalf of the Provider:

~~_____~~

Date: 2

Appendix 5: TVEP Permission

This was the permission granted, followed by the confidentiality agreement. Not sure how to put it as an appendix

----- Forwarded message -----

From: Masikhwa <legalofficer@tvep.org.za>

To: 'Managa Lilian' <nethavhanilily@yahoo.com>

Cc: "atj@tvep.org.za" <atj@tvep.org.za>; "traumacentermanager@tvep.org.za" <traumacentermanager@tvep.org.za>; 'Debrah' <hr@tvep.org.za>; 'Paida' <financemanager@tvep.org.za>

Sent: Monday, 21 September 2020, 15:40:05 SAST

Subject: RE: Letter to request permission to conduct a study and ethical clearance from the university

Dear Lilian.

Permission is hereby granted but we must draw up an agreement which will also state that TVEP will not incur any cost as a result of your study. This implies that you must cover their transport if clients will have to come to the office and refreshments. You must also contribute to our phone bill when TVEP makes arrangements with them. I intended to discuss this face-to-face with you as per your WhatsApp message when you said you will bring the letter to the office today.

You will also be required to sign our confidentiality clause.

Hope you find all in order.

Masikhwa Tshilidzi
Executive Director
Thohoyandou Victim Empowerment Programme (TVEP)
079 286 7973
015 963 1222

Appendix 6: Consent Form

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, Nethavhani Lilian about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number:
- I have also received, read and understood the above-written information (*Participant Letter of Information*) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth and initials will be anonymously processed into a study report.
- Given the requirements of research, I agree that the data collected during this study can be processed in a computerized system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during this research which may relate to my participation will be made available to me.

Full Name of Participant

Date Time Signature

I...Nethavhani Lilian.....

(*Name of the researcher*) herewith confirm that the above participant has been fully

Informed about the nature, conduct and risks of the above study.

Full Name of Researcher. NethavhaniLilian.....

Date..... Signature.... 

Full Name of Witness (If applicable)

..... Date Signature.....

Full Name of Legal Guardian (If applicable)

..... Date..... Signature.....

Please note the following:

Research details must be provided in a clear, simple and culturally appropriate manner and prospective participants should be helped to arrive at an informed decision by use of appropriate language (grade 10 level- use Flesch Reading Ease Scores on Microsoft Word), selecting a non-threatening environment for interaction and the availability of peer counselling (Department of Health, 2004)

If the potential participant is unable to read/illiterate, then a right thumb print is required and an impartial witness, who is literate and knows the participant e.g. parent, sibling, friend, pastor, etc. should verify in writing, duly signed that informed verbal consent was obtained (Department of Health, 2004).

If anyone makes a mistake completing this document e.g. a wrong date or spelling mistake, a new document has to be completed. The incomplete original document has to be kept in the participant's file and not thrown away, and copies thereof must be issued to the participant.

Appendix 7: Questionnaire

Instruction :Kindly mark with an X in the block with the relevant answer.

Indicate the number in the block where the question requires a number e.g How many kids ?

QN	Questions	
	SECTION A: PERSONAL INFORMATION	
1.	Marital Status	
	1. Married	1
	2. Widowed	2
	3. Divorced	3
	4. Separated	4
	5. Staying together not married	5
	6. Not married and not staying together	6
2.	Age	
	20-29	1
	30-39	2
	40-49	3
	50-59	4
	60-69	5
3.	Age at marriage	
	Below 20	1
	20-29	2
	30-39	3
	40-49	4
	50-59	5
	60 and above	6
4.	Religious Affiliation	
	Christianity	1
	Islam	2
	Hindu	3
	African Religion/traditional	4
	Other	5
5.	Highest Level of education	
	Illiterate	1
	Primary	2
	Secondary	3
	Tertiary	4
6.	Do you have children?	
	Yes	1
	No	2
7.	If yes: How many are from the same?	
	One	1
	Two	2
	Three	3
	Four	4
	Five and above five	5
8.	If yes: How many are not from the same relationship?	
	One	1
	Two	2

	Three	3
	Four	4
	Five and above	5
9.	Are you working?	
	Yes	1
	No	2
10.	If yes: what is your income?	
	Below R3 500	1
	R3 501 – R 10 000	2
	R10 001 – R 20 000	3
	R20 001 – R 30 000	4
	R30 001 – R 40 000	5
	R40 001 and above	6
11.	What is your partner highest Level of education?	
	Illiterate	1
	Primary	2
	Secondary	3
	Tertiary	4
12.	Is your partner employed?	
	Yes	1
	No	2
13.	If yes, what is his income?	
	Below R3 500	1
	R3 501 – R 10 000	2
	R10 001 – R 20 000	3
	R20 001 – R 30 000	4
	R30 001 – R40 000	5
	R40 001 and above	6
14.	Do you use alcohol?	
	Yes	1
	No	2
15.	Does your spouse use alcohol?	
	Yes	1
	No	2
	Access to media	
16.	Watches television and listens to radio	
	Watches television	1
	Listens to Radio	2
	All of the above	3
	None of the above	4
	Decision-making autonomy	
17.	Final say on own health	
	Not at all	1
	Full or partial	2
18.	Final say on household purchases for daily needs	
	Not at all	1
	Full or partial	2
	SECTION C: INTIMATE PARTNER VIOLENCE KNOWLEDGE	
	Component of knowledge	

19.	Which of the following types of behaviour occurring between a husband and wife would you consider to be covered by the term IPV?	Yes	No
	Being slapped or pushed by an intimate partner is a form of IPV		
	Being forced to have sexual intercourse by an intimate partner is a form of IPV.		
	Being scorned is a form of violence against women if committed by intimate partners.		
		Yes	No
	Any conduct that consists of deprivation of work tools, assets or economic resources is considered to be domestic violence		
	Being scared or intimidated on purpose by intimate partner is considered intimate partner violence		
20.	Are you aware of the effects of IPV on the following?		
	Affects health		
	Affects economy		
	Affects family		
	Affects children		
	Affects society		
21.	Which of the following factors do you think cause IPV?		
	“Women depending on men for food, shelter and other material things are more likely to become victims of domestic violence. ”		
	“Unemployed men tend to get frustrated and depressed, which lead to domestic violence. ”		
	“The lack of resources (e.g. house, money etc.) increases the likelihood of domestic violence. ”		
	“Drug and alcohol dependence can lead to domestic violence. ”		
	“Boys who witness their fathers’ violence towards their mothers are more likely to be violent when they grow up. ”		
	“The high level of women’s education can lead to domestic violence. ”		
	“Low educational level of men leads to domestic violence. ”		
	“Misinterpretation of religious texts in which men have rights to use domestic violence in order to correct women. ”		
	“Lack of education of women is a cause of domestic violence. ”		
	“Tolerance of domestic violence against women leads to its recurrence.”		
	“The inherent inequality between male and female in society leads to domestic violence.”		
		Yes	No
22.	Are you aware of the following available IPV prevention and support services available to you?		
	Placating		
	“Tried to avoid him		
	“Tried to avoid an argument with him		
	“Appeasing the husband and trying to act more intimate toward him		
	Tried to improve your behavior toward him		
	Staying away from him when he is on edge		
	Resistance		
	Fought back verbally		
	Refused to do what he said		
	Ended (or tried to end) the relationship		
	Used or threatened a weapon against him		

	Left home to get away from him				
	Chose to sleep separately from him				
	Fought back physically				
	Safety Planning				
	Put a knife, gun, or other weapon nearby				
	Hid the car or house keys				
	Kept money and other valuables hidden				
	Developed code so others know were in danger				
	Worked out an escape plan				
	Removed or hid weapons				
	Kept important phone numbers to get help				
	Changed locks or improved security				
		Yes	No		
	Kept important papers hidden from him				
	Kept extra supply of necessities				
	Legal				
	Filed a petition for a protection order				
	Sought help from legal aid				
	Filed or tried to file criminal charges				
	Called police or asked someone else to intervene				
	Filing for divorce in court				
	Formal Network				
	Tried to get help from employer/coworker				
	Stayed at a shelter				
	Tried to get help from clergy, pastor, etc.				
	Tried to get him counselling for violence				
	Made effort to have him get assistance for alcohol or/and substance abuse				
	Called mental health counsellor for self				
	Talked with domestic violence program				
	Talked to a doctor or nurse about the abuse				
	Informal Network				
	Asking her parents and brothers for help and support				
	Sent children to stay with friend/relative				
	Made sure other people are around you				
	Stayed with family or friends				
	SECTION D: MOTIVATION				
23.	For each statement, please specify the extent of your agreement or disagreement				
	To what extent do you agree that women should try to prevent this behaviour by?	Strongly Agree	Agree	Disagree	Strongly Disagree
	Placating				
	Tried to avoid him				
	Tried to avoid an argument with him				
	Appeasing the husband and trying to act more intimate toward him				
	Improving her behaviour toward him				
	Staying away from him when he is on edge				
	Resistance				
	Fought back verbally				

	Refused to do what he said				
	Ended (or tried to end) the relationship				
	Used or threatened a weapon against him				
	Left home to get away from him				
	Chose to sleep separately from him				
	Fought back physically				
	Safety Planning				
	“Put a knife, gun, or other weapon nearby”				
	“Hid the car or house keys”				
	“Kept money and other valuables hidden”				
	“Developed code so others know you were in danger”				
	“Worked out an escape plan”				
	To what extent do you agree that women should try to prevent this behaviour by?	Strongly Agree	Agree	Disagree	Strongly Disagree
	Removed or hid weapons				
	Kept important phone numbers to get help				
	Changed locks or improved security				
	Kept important papers hidden from him				
	Kept extra supply of necessities				
	Legal				
	Filed a petition for a protection order				
	Sought help from legal aid				
	Filed or tried to file criminal charges				
	Called police or asked someone else to intervene				
	Filing for divorce in court				
	Formal Network				
	Tried to get help from employer/coworker				
	Stayed at a shelter				
	Tried to get help from clergy, pastor, etc.				
	Tried to get him counselling for violence				
	Made effort to have him get assistance for alcohol or/and substance abuse				
	Called mental health counsellor for self				
	Talked with domestic violence program				
	Talked to a doctor or nurse about the abuse				
	Informal Network				
	To what extent do you agree that women should try to prevent this behaviour by?	Strongly Agree	Agree	Disagree	Strongly Disagree
	Asking her parents and brothers for help and support				
	Sent children to stay with friend/relative				
	Made sure other people are around you				
	Stayed with family or friends				
	Asking the husband’s parents for help and support				
	SECTION E: BEHAVIOURAL SKILLS/STRATEGY				


24.	Have you ever used each of the following strategy to deal with IPV occurrences? (yes/no)	Yes	No
	Placating		
	Tried to avoid him		
	Tried to keep things quiet for him		
	Tried not to cry during the violence		
	Tried to avoid an argument with him		
	Appeasing the husband and trying to act more intimate toward him		
	Tried to improve your behaviour toward him		
	Staying away from him when he is on edge		
	Resistance		
	Fought back verbally		
	Refused to do what he said		
	Ended (or tried to end) the relationship		
	Used or threatened a weapon against him		
	Left home to get away from him		
	Chose to sleep separately from him		
	To what extent do you agree that women should try to prevent this behaviour by?	Yes	No
	Fought back physically		
	Safety Planning		
	Put a knife, gun, or other weapon nearby		
	Hid the car or house keys		
	Kept money and other valuables hidden		
	Developed code so others know you were in danger		
	Worked out an escape plan		
	Removed or hid weapons		
	Kept important phone numbers to get help		
	Changed locks or improved security		
	Kept important papers hidden from him		
	Kept extra supply of necessities		
	Legal		
	Filed a petition for a protection order		
	Sought help from legal aid		
	Filed or tried to file criminal charges		
	Called police or asked someone else to intervene		
	Filed for divorce in court		
	Formal Network		
	Tried to get help from employer/coworker		
	Stayed at a shelter		
	Tried to get help from clergy, pastor, etc.		
	Tried to get him counselling for violence		
		Yea	No
	Made effort to have him get assistance for alcohol or/and substance abuse		
	Called mental health counsellor for self		
	Talked with domestic violence program		
	Talked to a doctor or nurse about the abuse		
	Informal Network		

	Asking her parents and brothers for help and support		
	Sent children to stay with friend/relative		
	Made sure other people were around you		
	Stayed with family or friends		
	Thank you		

Appendix 8: Checklist to Validate The PreCCL Strategy (Stakeholders and participants)

I am Nethayhani Managa Lilian, a PhD student at the University of Venda. I am conducting PhD in Public health, as a public health practitioner specialist in health promotion and health education. Title of the Study a study itled "Development of strategies to empower women against intimate partner violence (IPV) occurrences in Vhembe District" Limpopo Province. I am requesting you to review the strategies and checklists provided and then complete the relevance and acceptable validation questionnaires. Please answer questions using your best knowledge about the relevance and acceptability intended to empower women against intimate partner violence occurrences. The information you provide will be used to validate the strategies.

It is within your rights to withdraw from (the study) answering the questionnaire when you feel so. This questionnaire does not contain any offensive material. There are no risks, liabilities or benefits associated with answering this questionnaire and participating in the study. I am assuring you that all responses will remain confidential as regulated by the Ethical policy of the University of Venda. Do not write your name or company name on this questionnaire as your identity must remain confidential. Show your consent by appending your signature in the spaces below and your title e.g. Director VEPC or HOD and the name of the department

Signature of researcher:  Date:

Signature of a person validating: Title:

Date :

Title of the Study: Development of strategies to empower women against intimate partner violence occurrences in Vhembe District, Limpopo Province.

Purpose of the study: To develop the strategies to empower women against IPV occurrences in the Vhembe district

Purpose: The purpose of this checklist is to validate the developed intervention strategy. The developed strategies allow the provision of information on the prevention of intimate partner

occurrences. Involvement of, religious faith-based organisations. The suggested strategies are as follows (Also see the attachment with detailed strategies):

- (i) Introduce the syllabus with IPV from the foundation phase.
- (ii) Special court dedicated to dealing with IPV Cases. Kangaroo courts to deal with cases of IPV in deep rural areas. IPV cases to be prioritised in courts and harsh sentences to be passed so that those who are thinking of committing the same crime must think twice before committing such acts.
- (iii) Awareness and campaigns are at taxi/bus ranks, every mall, church, community meetings etc.
- (iv) Improving the upbringing of the young boys so that they should not use violence to address issues but instead negotiation imposition.
- (v) Dedicated school health practitioners at our schools.
- (vi) Community-based strategy covers involving men and women in the programs of addressing IPV issues as well as teaching a boychild how to treat a girlchild.
- (vii) Introduce a pocket-size card with information on available services for victims.

A checklist questionnaire to validate the developed strategies. Instruction: Kindly indicate your assessment of each component with a tick (✓) and comment in the comment section.

Strategies validation Items	Ratings of items				
	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
1. The purpose of the strategy's goal is clearly stated	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
2. The strategies are easy to understand	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
3. How relevant are the strategies to the types of IPV problems being involved	All very Relevant	All relevant	Some relevant	Some not relevant	All not relevant
4. There are no similarities among evaluation criteria in different components of strategies	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
5. The sequencing of the strategies is acceptable	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
6. The strategies are easy to implement within the communities	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
7. The strategies are inclusive of victims and perpetrators	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
8. The strategies reflect the ideas of the participants	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
9. The strategies are gender-transformative	Strongly agree	Agree	Not sure	Disagree	Strongly disagree

10. The strategies address IPV preventive methods in the community	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
11. The strategies have the potential of empowering IPV victims	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
12. The strategies are gender-neutral	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
13. The strategies are easily accessible to IPV and other community members	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
14. How important are these strategies in addressing IPV in your community?	Very important	Important	Little important	Not sure	Not important

Comments-----

Appendix 9: Checklist to Validate The PreCCL Strategy (Stakeholders and participants)

I am Nethavhani Managa Lilian, a PhD student at the University of Venda. I am conducting a study titled "Development of strategies to empower women against intimate partner violence (IPV) occurrences in Vhembe District, Limpopo Province". I am requesting you to review the strategies and checklists provided and then complete the relevance and acceptable validation questionnaires. Please answer questions using your best knowledge about the relevance and acceptability intended to empower women against intimate partner violence occurrences. The information you provide will be used to validate the strategies.

It is within your rights to withdraw from (the study) answering the questionnaire when you feel so. This questionnaire does not contain any offensive material. There are no risks, liabilities or benefits associated with answering this questionnaire and participating in the study. I am assuring you that all responses will remain confidential as regulated by the Ethical policy of the University of Venda. Do not write your name or company name on this questionnaire as your identity must remain confidential. Show your consent by appending your signature in the spaces below and your title e.g. Researcher, Director VEPC or HOD and the name of the department.

Nethavhani

Signature of researcher :

Date: 2022.02.15

Signature of a person validating: See original manual document Title: Pastor

Date: 2022.02.15

Title of the Study: Development of strategies to empower women against intimate partner violence occurrences in Vhembe District, Limpopo Province.

Purpose of the study: To develop the strategies to empower women against IPV occurrences in the Vhembe district

Purpose: The purpose of this checklist is to validate the developed intervention strategy. The developed strategies allow the provision of information on the prevention of intimate partner occurrences. Involvement of, religious faith-based organisations. The suggested strategies are as follows(Also see the attachment with detailed strategies):

- (i) Introduce the syllabus with IPV from the foundation phase.
- (ii) Special court dedicated to dealing with IPV Cases. Kangaroo courts to deal with cases of IPV in deep rural areas. IPV cases to be prioritised in courts and harsh

sentences to be passed so that those who are thinking of committing the same crime must think twice before committing such acts.

- (iii) Awareness and campaigns are at taxi/bus ranks, every mall, church, community meetings etc.
- (iv) Improving the upbringing of the young boys so that they should not use violence to address issues but instead negotiation imposition.
- (v) Dedicated school health practitioners at our schools.
- (vi) Community-based strategy covers involving men and women in the programs of addressing IPV issues as well as teaching a boychild how to treat a girlchild.
- (vii) Introduce a pocket-sized card with information on available services for victims.

A checklist questionnaire to validate the developed strategies. Instruction: Kindly indicate your assessment of each component with a tick (✓) and comment in the comment section.

Strategies validation Items	Ratings of items				
	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
15. The purpose of the strategy's goal is clearly stated	Strongly agree	Agree ✓	Not sure	Disagree	Strongly disagree
16. The strategies are easy to understand	Strongly agree.	Agree ✓	Not sure	Disagree	Strongly disagree
17. How relevant are the strategies to the types of IPV problems being involved	All very Relevant	All relevant ✓	Some relevant	Some not relevant	All not relevant
18. There are no similarities among evaluation criteria in different components of strategies	Strongly agree✓	Agree	Not sure	Disagree	Strongly disagree
19. The sequencing of the strategies is acceptable	Strongly agree	Agree ✓	Not sure	Disagree	Strongly disagree
20. The strategies are easy to implement within the communities	Strongly agree	Agree ✓	Not sure	Disagree	Strongly disagree
21. The strategies are inclusive of victims and perpetrators	Strongly agree.	Agree ✓	Not sure	Disagree	Strongly disagree
22. The strategies reflect the ideas of the participants	Strongly agree	Agree ✓	Not sure	Disagree	Strongly disagree
23. The strategies are gender-transformative	Strongly agree	Agree ✓	Not sure	Disagree	Strongly disagree
24. The strategies address IPV preventive methods in the community	Strongly agree	Agree	Not sure✓	Disagree	Strongly disagree

25. The strategies have the potential of empowering IPV victims	Strongly agree √	Agree	Not sure	Disagree	Strongly disagree
26. The strategies are gender-neutral	Strongly agree	Agree √	Not sure	Disagree	Strongly disagree
27. The strategies are easily accessible to IPV and other community members	Strongly agree	Agree √	Not sure	Disagree	Strongly disagree
28. How important are these strategies in addressing IPV in your community?	Very important √	Important	Little important	Not sure	Not important

Comments- Pastor Male Married 48 YEARS

For our community to minimize the IPV in our homes and community at large, I think different centres that cater to different readers can be established e.g. men, women and children where all these groups can be addressed concerning IPV. Pastors in different congregations and churches host couples seminars and teach men the importance of love as the word of God in Ephesians commands the to do so

I should believe the accessible place in the church, schools and community halls, etc.

From the religious point of view if the church can be given a pivotal role in addressing the communities having the support of the community leader can be also helpful. In all institutions, churches, schools, different groups and organizations (text missing will insert immediately when I receive)

Pastors in different congregations and churches host couples seminars and teach men the importance of love as the word of God in Ephesians command the to do so-

Appendix 10: interview Guide

SECTION A: Socio-demographic data

1. Tell me more about yourself and your spouse

Age			
Marital status/Living arrangement			
Number of children			
Level of education			
Employment status			
Income			
Partner's age			
Partners' level of education			
Partner's employment status			
Partners' income			
Are you a breadwinner	Yes	If no, who is the main breadwinner	Total monthly income

Main source of Income	
-----------------------	--

SECTION B: Personal experiences of intimate partner violence.

-
- 1) What are the predisposing/contributing factors and perceived reasons for your abuse?
Can you kindly share with me your experiences of intimate partner violence?
 - 2) Can you kindly share with me your experiences of intimate partner violence?
 - 3) Can you share with me the services which you used as well as the methods and strategies that you have used previously to deal with intimate partner violence and did all those method/s that you used to mitigate intimate partner violence helped?

- 4) What are alternative methods of dealing with IPV did you use and how effective were those alternative methods in alleviating IPV?
- 5) What challenges do you as a victim find when using existing available and existing methods of dealing with IPV?
- 6) When you are abused like this, what are the effects and their severity, does that mean is spontaneous or planned, tell me more about the pattern, and how does it affect your relationship with him and other people?
- 7) What do you think should be done to curb IPV?
- 8) What are strategies that can be used to empower women against IPV occurrences in Vhembe District?
- 9) Tell me if you were to change one thing from your spouse or your situation what were you going to change.

