THE FIRST SOUTH AFRICAN NATIONAL GENDER-BASED VIOLENCE STUDY, 2022

A Baseline Survey on Victimisation and Perpetration

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RESEARCH REPORT

The First South African National Gender-Based Violence Study:
A Baseline Survey on Victimisation and Perpetration

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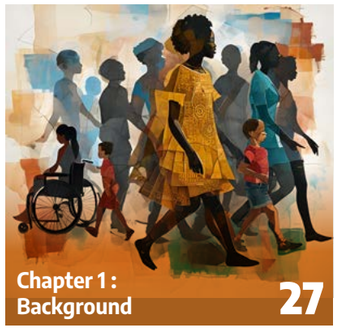

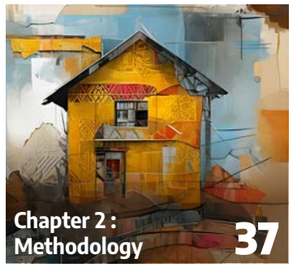

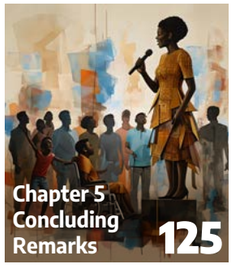

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CONTRIBUTORS

Research team

Human Sciences Research Council

Dr Nompumelelo Zungu
Principal Investigator

Prof. Khangelani Zuma
Principal Investigator

Dr Natisha Dukhi
Project Director, Co-Investigator

Dr Zaino Petersen
Project Director, Co-Investigator

Dr Whadi-ah Parker
Project Manager, Co-Investigator

Dr Tawanda Makusha
Project Manager, Co-Investigator

Dr Musawenkosi Mabaso
Co-Investigator

Ms Ronel Sewpaul
Co-Investigator

Dr Inbarani Naidoo
Co-Investigator

Mr Phaleng Maribe
Co-Investigator

Ms Goitseone Maseko
Co-Investigator

Mr Adlai Davids
Co-Investigator

Dr Thabang Manyaapelo
Co-Investigator

Ms Lactricia Maja
PhD. Intern

Ms Ruth Makgalemane
PhD. Intern

Ms Prudence Chambale
PhD. Intern

Mr Sbonelo C Chamane
Masters Intern

Ms Kutloano Skhosana
Masters Intern

Dr Dane Isaacs
Co-Investigator, Provincial Coordinator

Ms Philisiwe Ndlovu
Provincial Coordinator

Ms Londiwe Shandu
Provincial Coordinator

Ms Nokubonga Zondi
Provincial Coordinator

Ms Noloyiso Vondo
Provincial Coordinator

Dr Derrick Sekgala
Provincial Coordinator

Dr Karabo Mohapanele
Provincial Coordinator

Mr Frederick Tshitangano
GIS

Mr Nhlanhla Sihlangu
IT/Data Technician

Mr Thabiso Tshetlho
IT/Data Technician

South African Medical Research Council

Ms Nada Abdelatif
Co-Investigator

Dr Tarylee Reddy
Co-Investigator

Ms Nobuhle Mchunu
Statistician

University of Cape Town

Prof. Benita Moolman
Co-Investigator

Civil Society

Ms Pinky Mgobozi
Consultant

Administration and financial management

Ms Claudia Nyawane
Financial manager

Ms Sue Samuels
Administrator

Ms Sinazo Ndiki
Administrator

Ms Jill Ramlochan
Administrator

Ms Sharon Felix
Adiministrator

Independent technical/ Expert reviewers of the report

Dr Andy Gibbs
University of Exeter

Dr Chandre Gould
Institute for Security Studies

Ms Isabella Schmidt
UN Women

Prof. Mzikazi Nduna
Independent Consultant

Prof. Nicholas Metheny
Emory University & University of Cape Town

Ms Sarah Reis
UNFPA East and Southern Africa Regional Office

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Government reviewers of the report

The Private Office of the President

Dr Olive Shisana, Ms Tamara Braam, Ms Sibongile Mthembu, Ms Namhla Mniki-Mangaliso and Ms Ayanda Zwane

Department of Planning Monitoring and Evaluation & Private Office of the President

Dr Harsha Dayal

Briefings: Department of Women, Youth, and Persons with Disabilities

The report was presented to the **Honorable Minister Sindisiwe Chikunga** on the 27th of July 2024 and again on the 1st of October 2024. The meetings were attended by senior officials from the Department of Women, Youth and Persons with Disabilities. The first engagement with the Minister included officials from the Private Office of the President.

Department of Science Technology and Innovation

The report was also presented to **Honorable Minister Blade Nzimande** on the 9th of October 2024. The meeting was attended by senior officials and advisors in the Department and the Minister's office.

ACRONYMS AND ABBREVIATIONS

AGYW	Adolescent girls and young women
CBO	Community-based organisation
CES-D	Centre for Epidemiologic Studies Depression scale
DHS	Demographic and Health Survey
GBV	Gender-based violence
GBVF	Gender-based violence and femicide
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
IPV	Intimate partner violence
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer, intersex, asexual and other extensions
LMICs	Low- and middle-income countries
NDoH	National Department of Health
NGO	Non-governmental organisation
NSP GBVF	National Strategic Plan on Gender-Based Violence and Femicide
PPS	Probability proportional to size
PSU	Primary sampling unit
PTSD	Post-traumatic stress disorder
SABSSM	South African National HIV Prevalence, Incidence, Behaviour, and Communication Survey
SADHS	South African Demographic and Health Survey
SALs	Small area layers
SDG	Sustainable Development Goal
SGBV	Sexual and gender-based violence
SSA	Sub-Saharan Africa
SSUs	Secondary sampling units
STIs	Sexually transmitted infections
UN	United Nations
USU	Ultimate sampling unit
VAW	Violence against women
VAWG	Violence against women and girls
VPs	Visiting points
WHO	World Health Organization

GLOSSARY OF TERMS

Consent	An exercise of choice and a voluntary agreement to engage in sexual activity with another party. Consent is an ongoing process and can be withdrawn at any time. Consent to engage in sexual activity is compulsory in every sexual act, always matters, and should not be assumed, regardless of the relationship status and irrespective of previous sexual activity with the other party.
Disability	Disability is imposed by society when a person with a physical, psychosocial, intellectual, neurological and/or sensory impairment is denied access to full participation in all aspects of life, and when society fails to uphold the rights and specific needs of individuals with impairments.
Domestic violence	According to South African law, this includes physical abuse; sexual abuse; emotional, verbal and psychological abuse; economic abuse; intimidation; harassment; stalking; entry into the complainants' residence without their consent or any other controlling or abusive behaviour taking place in domestic relationships.
Economic abuse	Includes the unreasonable deprivation of economic or financial resources, which a complainant is entitled to under law or requires out of necessity, and the unreasonable disposal of household effects or other property in which the complainant has an interest.
Family and household	A family only includes people who are related. A well-functioning family provides members with emotional, social, spiritual and material support that is sustained throughout life, and it also represents the cradle from which the values and norms of a society are transmitted and preserved, and is therefore a key institution for transforming values and norms. A household is a person or group of persons that usually lives and eats together. Furthermore, a household may consist of multiple families.
Femicide	Also known as female homicide, is generally understood to involve intentional murder of women because they are women, but broader definitions include any killing of women or girls. In South Africa, it is defined as the killing of a female person, or a person perceived as female, on the basis of gender identity, whether committed within a domestic relationship, interpersonal relationship or by any other person, or whether perpetrated or tolerated by the State or its agents. Intimate femicide is defined as the murder of women by intimate partners, i.e. 'a current or former husband or boyfriend, same-sex partner, or a rejected would-be lover'.
Gender	The socially constructed identities assigned to the biological characteristics of people in society. The concept of gender includes the values, attitudes, feelings, and behaviours as well as the interactions and relationships associated with being a woman (femininity) and being a man (masculinity) in a given culture and setting. These are also influenced by social, historical and cross-cultural factors.
Gender-based violence	The general term used to capture violence that occurs as a result of the normative role expectations associated with the gender (and sexuality) associated with the sex assigned to a person at birth, as well as the unequal power relations between the genders, within the context of a specific society. GBV includes physical, sexual, verbal, emotional, and psychological abuse or threats of such acts or abuse, coercion, and economic, social contact or educational deprivation, whether occurring in public or private life, in peacetime and during armed or other forms of conflict, and may cause physical, sexual, psychological, emotional or economic harm.

Gender identity	A person's internal, deeply held sense of their gender as being male, female, both, or neither. People whose gender identity matches the sex assigned to them at birth are cisgender. Transgender people are those whose internal gender identity does not match the sex they were assigned at birth. Most people have a gender identity of man or woman (or boy or girl). For some people, their gender identity does not fit neatly into one of those two choices (see non-binary and/or gender queer below). Unlike gender expression, gender identity is not visible to others.
Human rights	Rights inherent to all human beings, regardless of race, sex, nationality, ethnicity, language, religion, or any other status. Human rights include civil, political, social and economic rights. For instance, these include the right to life and liberty, freedom from slavery and torture, freedom of opinion and expression, the right to work and education, and many more. Everyone is entitled to these rights, without discrimination.
Intersectionality	Intersectionality refers to overlapping social identities and the related systems of oppression and domination that use these to marginalise and exclude. Although all women face discrimination some women face multiple forms of oppression because of their race, ethnicity, religion, socio-economic background, abilities and sexual orientation, which in turn shapes their experiences of violence. Intersectionality looks at the relationships between these different forms of oppression and allows for analysis of social problems more fully, shapes more effective interventions, and promotes more inclusive responses.
Intimate partner violence	Intimate partner violence usually consists of a pattern of assaultive and coercive behaviours, including physical, sexual and psychological attacks, as well as economic coercion, by a current or former intimate partner.
LGBTQIA+	LGBTQIA+ refers to persons who identify as lesbian, gay, bisexual, transgender, queer, intersex or asexual. The + is used to include individuals who are questioning, a romantic, pansexual, non-binary, gender fluid, genderqueer, agender or an LGBTQIA+ ally.
Locality type	Urban formal refers to cities, towns, townships and suburbs excluding informal settlements; urban informal or informal and squatter settlements refers to unplanned settlement on land which has not been surveyed or proclaimed as residential; rural informal refers to tribal areas; rural formal refers to farm areas including commercial farms.
Non-partner	Individuals who are not in an intimate or marital relationship with the person in question. This includes, but is not limited to, family members (other than a spouse or intimate partner), friends, acquaintances, colleagues, and strangers.
Patriarchy	Patriarchy is a social system in which men hold primary power and dominate in leadership roles, establishing moral authority, acquiring social privilege, and in the control of property. Patriarchy is a form of colonial governance.
Persons with disability	Persons with disability include those who have or are perceived to have, physical, psychosocial, intellectual, neurological and/ or sensory impairments which, as a result of various attitudinal, communication, physical and information barriers that hinder their participating fully and effectively in society on an equal basis with others.
Rape	According to the Criminal Law (Sexual Offenses and Related Matters) Amendment Act, 2007[2], rape is the unlawful and intentional sexual penetration of a person by another without consent. The Act defines 'sexual penetration' as including the oral, anal or vaginal penetration of a person (male or female, regardless of age) with a genital organ; anal or vaginal penetration with any object or any part of the body of an animal, or the penetration of a person's mouth with the genital organs of an animal.

Risk factor	Risk factor is an event or situation that increases the possibility of a negative outcome for an individual.
Safety	Safety refers principally to the social conditions that instill a feeling of being protected from danger, harm, risk, or injury, and is based on the real and perceived risk of physical and emotional victimisation.
Sex	Sex refers to the biological or anatomical characteristics that a person is born with and is usually determined on the basis of the appearance of external genitalia, namely a vagina to denote female and a penis and testes to denote male. Sex is also a synonym for sexual intercourse, which includes penile-vaginal sex, oral sex, and anal sex. Intersex is a general term used for a variety of conditions in which a person may be born with reproductive or sexual organs that do not fit the typical definition of male or female. For example a person might be born appearing to be female on the outside but have mostly male reproductive organs on the inside or they might be born with genitals that seem in between the usual male and female types, for example a girl born with a noticeably large clitoris or lacking a vaginal opening or a boy may be born with a noticeably small penis or with a scrotum that is divided so that it forms more like labia (vaginal lips). However, it is possible to change a sex by having a sex change operation.
Sexual and reproductive health	A state of complete physical, mental and social wellbeing in all matters relating to the reproductive system and sexuality; it is not merely the absence of disease, dysfunction or infirmity. For sexual and reproductive health to be attained and maintained, the sexual and reproductive health rights of all persons must be respected, protected and fulfilled. Sexual and reproductive health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.
Social Norms	Unwritten rules that regulate acceptable behaviour in a group. Social norms define what is expected of people in society; they are both embedded in institutions and nested in people's minds.
Transphobia	Transphobia is the fear, hatred, disbelief, or mistrust of people who are transgender, thought to be transgender, or whose gender expression does not conform to traditional gender roles, that is, the behaviours, values, and attitudes that a society considers appropriate for either male or female.
Ukuthwala	A form of abduction under the guise of patriarchal tradition and culture that involves kidnapping a girl or a young woman by a man and his friends or peers with the intention of compelling the girl or young woman's family to agree to marriage. It has been marked by violence and rape.
Violence	The intentional use of physical force or psychological power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation.
Violence against women	Any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life. It refers to violence directed at a woman because she is a woman and that affects her disproportionately. It takes a range of forms including but not limited to intimate partner violence, non-partner sexual assault, trafficking, so-called honour crimes, sexual harassment and exploitation, stalking, witchcraft-related violence, and gender-related killings.
A person made vulnerable	Any person who belongs to a group within society that is either oppressed or more susceptible to come to harm.
Woman	Used in this document to refer to a person that defines themselves as female and includes not only cis women, but also trans women and femme/feminine-identifying genderqueer and non-binary persons.

EXECUTIVE SUMMARY

Introduction

This report presents the findings of the first 'fit-for-purpose' national study on the prevalence of gender-based violence (GBV) in all nine provinces of South Africa. It outlines the prevalence of physical, sexual, emotional, and economic violence, and psychological abuse such as controlling behaviour among youth and adults 18 years and older. It also examines the perpetration of violence by men against their female partners and the underlying role of gender norms in driving GBV. The results provide new evidence and confirmation of the patterns of violence against women in the country. The study findings contribute to understanding the life course of victimisation and perpetration in South Africa.

The study also serves as a vital source of information for government, researchers, academics, civil society, developmental partners, policy makers, and practitioners. It represents a step forward and provides empirical evidence about GBV in South Africa. The data collected are an important source for reporting and tracking progress in addressing GBV in South Africa, as outlined in the National Strategic Plan (NSP) on Gender-Based Violence and Femicide (GBVF). The study allows the country to report prevalence estimates that are comparable to other countries that have adopted the World Health Organization (WHO) globally recognised approach for measuring GBV.

Background

South Africa remains a society profoundly marked by violence and continues to grapple with the enduring effects of decades of institutionalised racism, sexism, exclusion, structural violence, and other factors that have persistently undermined human development and positive social cohesion.[1] The country contends with some of the globe's highest homicide data and some suggest the country has one of the highest rates of GBV, encompassing intimate femicide, rape, and intimate partner violence (IPV).[2,3] The President of South Africa acknowledged that GBV is a severe socio-economic problem, which is fundamentally rooted in unequal power dynamics between women and men.[4] Violence against women has been acknowledged as a 'national crisis' and a 'second pandemic' that is increasingly recognised not just as a national issue but also as serious human rights abuse and an increasingly important psychosocial and public health concern that affects all sectors of society.[5-8] GBV in the country transcends cultural, socio-economic, ethnic, and other socio-demographic diversities.[6,7].

The persistence of GBV reflects deeply ingrained societal norms and structures that perpetuate male dominance and reinforce gender hierarchies and power imbalances within families and communities, leading to female subordination, systemic inequalities, and violence against women.[9]

Accurately determining the prevalence and incidence of GBV in all its forms is challenging. The country has depended on police data and statistics that have been derived mostly from provincial GBV surveys, GBV studies within selected populations, and data from other national surveys that were not designed for GBV, such as the Victims of Crime, Governance, Public Safety and Justice Survey, the South African Demographic and Health Survey (SADHS), and the South African National HIV Prevalence, Incidence, Behaviour, and Communication Survey (SABSSM). Police data is known for pervasive under-reporting and inadequate documentation of cases. Contributing factors include the lack of an integrated national surveillance system, stigma, fear of retaliation, and lack of trust in authorities tasked to respond to GBV.[10] Despite these challenges, over the past decade, there has been a concerted effort by grassroots and international civil society organisations, international experts, researchers, academics, and governments, which has led to a significant transformation in public awareness of GBV. This activism has further led to advocacy for the measurement of GBV using nationally representative population-based samples and internationally recognised methodologies and instruments. To this end, the Human Sciences Research Council (HSRC) and its collaborators were tasked with undertaking a study aimed at assessing the prevalence, extent and nature of GBV and its impact (consequences) across the country.

Aims and objectives

1. To describe the prevalence and patterns of experiences of physical, sexual, emotional and economic GBV among women from all provinces in South Africa

2. To describe the prevalence and patterns of perpetration of physical, sexual, emotional and economic GBV among men from all provinces in South Africa

3. To determine factors associated with GBV victimisation and perpetration, including:

- **3.1.** Gender, sexual norms and attitudes
- **3.2.** Socio-behavioural risk factors including alcohol and substance use, condom use, number of sexual partners and transactional sex
- **3.3.** Mental health, including depression among victims and perpetrators

4. To measure responses to experiences of GBV and the health and economic impacts of GBV among those who are victimised

5. To determine the extent of experiences and perpetration of GBV attributed to the COVID-19 pandemic and the lockdown period

Methodology

Study design

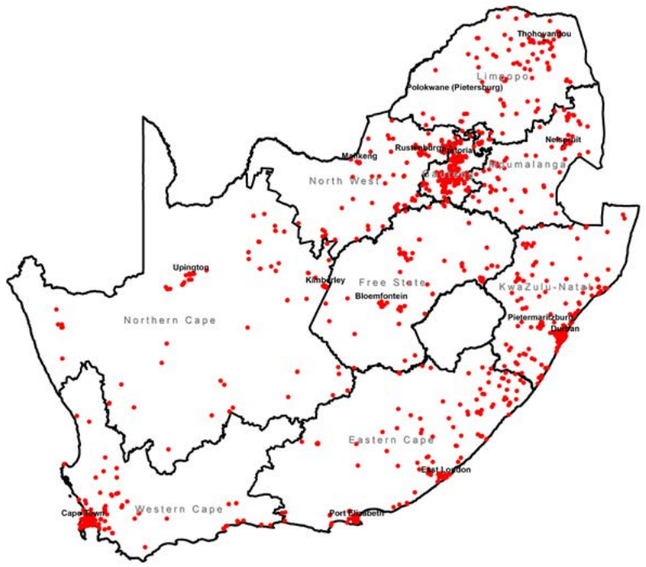
The study is a population-based household survey, conducted using a multi-stage stratified cluster random sampling design.

Study population and sampling

The study included individuals aged 18 years and older, living in households across all nine provinces of South Africa. People who were excluded from participating included, persons who were unable to give verbal consent or assent due to cognitive impairment or intellectual disability, and persons living in institutions. The probability proportional to size (PPS) sampling approach was used firstly to select 1 096 small area layers (SALs) using Statistics South Africa's 2020 national population sampling frame, which consists of 84 907 SALs forming a primary sampling unit (PSU). Half of the SALs were used to collect data from men and half from women. The selection of SALs was stratified by province and locality type, classified as urban, rural informal (tribal area), and rural formal (commercial farms). A cluster of 20 households were systematically randomly selected from each SAL to form a secondary sampling unit (SSU). Once in the household one individual aged 18 years and older was selected to complete a questionnaire. If there was more than one individual eligible to participate, one person was randomly selected using the Kish grid in each sampled household as the ultimate sampling unit (USU). This yielded a multi-stage stratified cluster random sampling design. The sample size calculations were informed by the 2016 Demographic and Health Survey national estimates of violence experienced by women in South Africa. The SADHS 2016 report estimated that the prevalence of lifetime physical violence among partnered women was 21%. This was used to calculate the sample because it was the closest available estimate of prevalence of violence that could be used in sample size estimation. An estimated total sample size of 19 671 was calculated in order to detect a 10% reduction in the overall prevalence of lifetime physical violence against women with 80% power at 5% level of significance, assuming a 70% response rate and a design effect of 2. Sample size allocation for each province was proportional to the population size as per the 2020 mid-year population estimates.

In an attempt to increase the participation of socially excluded and marginalised groups, such as LGBTQIA+ persons and people with disabilities, the study design was adapted

to include respondent-driven sampling (RDS) to supplement the household sampling approach after consulting experts in GBV survey methodology. Using this chain-referral sampling method, we attempted to access the social networks of eligible participants from the hard-to-reach population groups found in the households. A compensation/ reimbursement system was then introduced to facilitate RDS, whereby the individual selected at the household (the seed) would be asked to recruit other individuals like themselves. The introduction of a reimbursement system was approved by the HSRC Ethics Committee. To avoid stigmatisation of the participants recruited using RDS, and possible reports that some participants were reimbursed, and others were not, all participants were given a store voucher to the value of R50. An additional R30 cellphone voucher was provided for each successful referral in the RDS arm of the study. Despite these efforts, RDS did not yield the expected results and was dropped from the realised sample used in the analysis. In total only 153 people were sampled via RDS, of which 71 identified as belonging to the LGBTQIA+ community and 81 reported that they have a disability. A separate paper will be prepared using this sub-sample. It will also highlight challenges of using RDS at a household level and lessons learnt for future surveys.



Questionnaire development

To collect data that has the potential for comparison with data on GBV in other countries, the WHO Multi-Country Study on Women's Health and Life Experiences questionnaire and the United Nations Multi-Country Study on Men and Violence questionnaire[11] were used. The WHO Women's Health and Life Experiences Questionnaire version 12.06 and the Core Men's Questionnaire version 3.0 were adjusted to ensure cultural sensitivity, utilisation of common local terms where possible, and relevance to the South African context. All questionnaires were translated into the eleven official South African languages. Details of the measures used are provided in Appendix A. The women's questionnaire included modules on the characteristics of the respondent, general health status, reproductive health, Information regarding children, characteristics of current or most recent partner, attitudes toward gender roles, experiences of partner violence, injuries due to violence, impact and coping mechanisms used by women who experience violence, non-partner violence, COVID-19 lockdown-related violence and economic autonomy. The men's questionnaire included modules on characteristics of the respondent, childhood experiences, attitudes about relations between men and women, intimate relationships, health and wellbeing, policies, self-administered questions on violence perpetration and COVID-19 lockdown-related violence.

Recruitment and training of data collectors

Recruitment of field staff took place in 2021. Preference was given to candidates with previous experience in collecting survey data in the health and related fields, experience with gender and GBV work, or a qualification in social sciences such as psychology, sociology, counselling, community development, and gender-studies. Field teams were matched by sex (females collected data in female SALs and males in male SALs), gender, language and ethnicity to the demographics of the SALs selected in each province.

The training workshop was conducted over a period of two weeks. The first week focused on introducing the study and covered mostly the theoretical aspects such as: objectives of the study, sex and gender, gender sensitisation, masculinities, gender norms and roles, gender-based violence, study methodology, ethics in research, safety measures in field research, quality control, COVID-19 standard operating procedures (SOPs), roles and expectations of field staff, admin processes, and working and employment conditions. In the second week the focus shifted to the practical implementation of the study in the field. Training sessions focused on introducing the questionnaires, how to use computer-assisted personal interviews (CAPI) using portable tablets, and administering the consent form and the questionnaire. All trainees were required to participate in role play in which different scenarios were enacted to test their competence. Mental health SOPs for staff and participants were also introduced, coupled with practical ways of handling difficulties in the field. Trainees who did not meet the required pre-set standard in the purpose-specific competency tests were not issued with a contract to implement fieldwork.

Data collection

Survey teams were distributed, proportionally to size, throughout the nine provinces. Two project directors and two project managers oversaw the teams and the day-to-day implementation of the study. Additionally, six provincial coordinators offered support to field teams. Each team had a supervisor who supervised data collection.

Data collection was implemented from February 2022. Due to COVID-19-related restrictions, data collection had to be implemented in a phased approach. The full complement of teams started in March 2022. The average duration of data collection in a SAL was between five and seven days. If household members or the selected participant were not home, the data collector visited the household at different times of the day or over weekends to secure an interview. Households were visited up to three times.

Due to budgetary constraints, the survey was paused in December 2022, with data collection being incomplete. It was resumed in a mop-up study between November 2023 and February 2024. Four provinces were visited targeting SALs that could not previously be accessed. Quality assurance of fieldwork was implemented between September and December 2022.

Questionnaire administration

Questionnaires were administered by trained interviewers using computer-assisted personal interviews (CAPI) with the help of a portable tablet. All responses were entered directly into the portable tablet by the data collector during the interview, ensuring real-time data capture and reducing the risk of data entry errors. Given the sensitive nature of the perpetration sections of the men's questionnaire, this portion of the questionnaire was self-administered. This was done to enhance confidentiality and minimise fear of disclosing information and social desirability bias. Interviews were conducted in private and secure spaces within the household. If it was not safe to proceed, or if the interview was interrupted by the arrival of a partner, data collectors were trained to terminate the interview and reschedule where possible.

Safety and support for staff members and participants during fieldwork

The field teams were carefully managed to prioritise their safety and that of participants. To minimise potential harm and any GBV-related stigmatisation, a neutral study title was used: **'The South African National Survey on Health, Life Experiences, and Family Relations'.** This approach is recommended by the WHO. No reference to GBV or violence was made in any public communication or promotional material of the study. Only the consent form that was administered to one individual per household mentioned the nature and sensitivity of the survey. Consent was obtained verbally and recorded electronically; no hard copies were left in the household.

To minimise the impact of working with trauma and violence, each field team member was only allowed to interview three individuals per day. Support for staff members consisted of regular debriefing meetings, monitoring and oversight visits, daily supervision, and regular performance feedback aimed at sharing experiences and identifying staff members in need of additional support or care. From the start of the study, field staff were issued with a vicarious trauma SOP, and were supported through frequent discussions about the challenges and dilemmas that emerged during data collection. All staff members were provided with a toll-free number (that was printed at the back of their project ID tags) for the HSRC's Employee Assistance Programme (EAP) which could be accessed anytime when needed.

Maintaining safety for human participants is an important part of all research. SOPs for dealing with emotional distress and suicidal ideation were developed together with referral slips. During the training workshop, the supervisors and the data collectors were trained on how to deal with both. The SOPs also included a step-by-step guide on how to assess risk, escalate to the provincial coordinator if necessary, and refer to professionals in the area. Details of local and national NGOs that could be contacted in case of an emergency were also provided to the field teams. As part of community entry, teams were required to locate local service providers that could be used for referrals or additional support.

Data analysis

Data analysis was performed on two separate datasets. The datasets for men and women were kept separate because the questionnaire items and response options were different. Some measures and scales also differed between the two questionnaires. The socio-behavioural variables presented in this report therefore differ for men and women and some items used to compute composite variables differed between men and women. We refer the reader to Appendix B and Appendix C for detailed variable definitions for the outcomes for victimisation and perpetration and the socio-demographic and socio-behavioural variables for women and men, respectively.

Data analysis was performed using Stata version 18.0 and the figures were prepared in Microsoft Excel. A Chi-squared test was used to compare estimated proportions for categorical variables. The results depict weighted percentages, 95% confidence intervals (CIs), and p-values. Unweighted counts (n) are reported, unless otherwise specified. The sum of the individual unweighted counts may not be equal to the overall total due to missing data for certain demographic variables. Where applicable, weighted counts are presented in an effort to estimate the total number of women in the country who experienced forms of victimisation and the total men in the country who perpetrated violence.

Ethical considerations

Ethical clearance to conduct the study was granted by the Research Ethics Committee at the Human Sciences Research Council (REC No 5/27/01/21) in July 2021 and renewed annually thereafter. Research at the HSRC is carried out following the principles underlying a board-approved code of ethics, research ethics, and research integrity.

Results

In the women's SALs, 10 183 visiting points (VPs) were approached of which 9 317 (91.5%) were valid. A total of 5 603 women in the 5 768 VPs agreed to be interviewed with 97.1% being eligible. In the men's SALs, 9 623 VPs were approached of which 8 864 (92.1%) were valid. A total of 4 409 men in the 4 668 VPs agreed to be interviewed with 94.5% being eligible. The final total realised sample consisted of 10 012 participants, compared to the anticipated 19 671 participants.

Prevalence of violence among women

Figure 1 shows a summary of national prevalence estimates for physical, sexual, emotional, and economic violence, and psychological abuse such as controlling behaviour. We show proportions of all women aged 18 years and older who ever experienced lifetime and recent physical, sexual, physical and/or sexual violence regardless of partnered status, by intimate partners or non-partners. We also show the prevalence of different forms of violence by men against their intimate partners. Where applicable, weighted numbers are also provided.

Prevalence of physical and sexual violence among women regardless of partnered status

Prevalence of lifetime physical violence regardless of partnered status

Nationally, when we asked all women about their experiences of physical violence, we found that 33.1% [95% CI: 30.8-35.5] of all women aged 18 years and older had experienced physical violence in their lifetime. This translates to an estimated 7 310 389 women who have experienced physical violence in their lifetime (Figure 1). Lifetime physical violence was significantly higher among Black African women [35.5%, 95% CI: 32.9-38.1] compared to women of other race groups. Lifetime physical violence was also significantly higher among women who were cohabiting but not married [43.4%, 95% CI: 37.3-49.7] compared to women who were currently married and women who were not currently in a relationship.

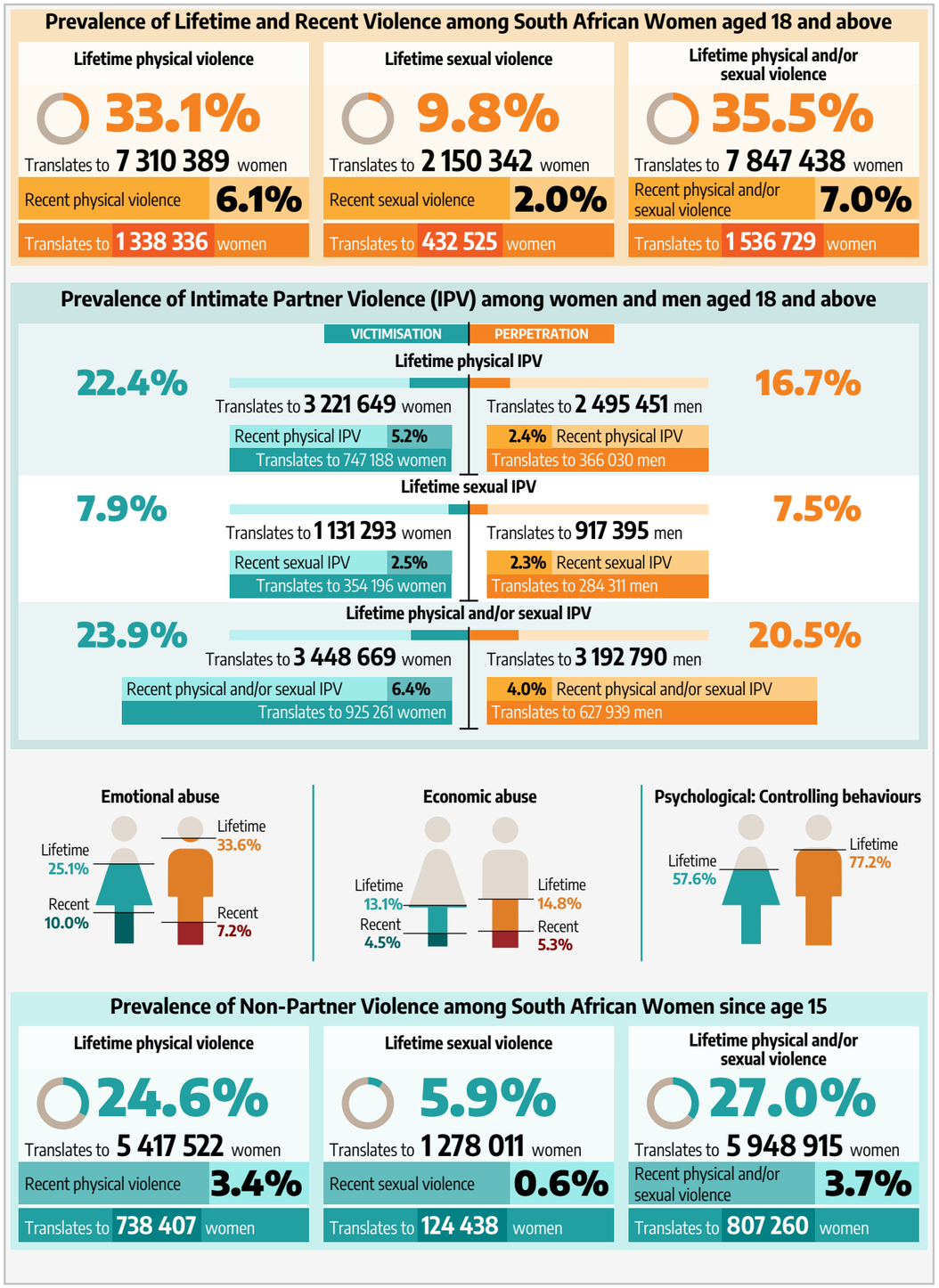
Prevalence of lifetime sexual violence regardless of partnered status

Nationally, we found that among all women, 9.8% [95% CI: 8.6-11.1] had experienced sexual violence in their lifetime. This translates to an estimated 2 150 342 women who have experienced sexual violence in their lifetime (Figure 1). Lifetime sexual violence was significantly higher among women who were cohabiting but not married [14.9%, 95% CI: 10.8-20.1] compared to women who were currently married [8.5%, 95% CI: 7.0-10.3].

Prevalence of lifetime physical and/or sexual violence regardless of partnered status

Nationally, 35.5% [95% CI: 33.2-37.9] of women reported experiencing lifetime physical and/or sexual violence during their lifetime. This translates to an estimated 7 847 438 women who experienced lifetime physical and or sexual violence in South Africa (Figure 1). Lifetime physical and/or sexual violence was significantly higher among women aged 35 – 49 years [38.0%, 95% CI: 34.3-41.9] than those aged 50 years and older. Black African women [37.9%, 95% CI: 35.3-40.6] were the most affected compared to other race groups. A higher proportion of women who were cohabiting but not married [47.9%, 95% CI: 41.8-54.0] reported experiencing lifetime physical and/or sexual violence, compared to women who were currently married and those who were not currently in a relationship.

Figure 1: Prevalence of different forms of gender-based violence among women and men aged 18 years and older, South Africa 2022



Prevalence of physical and sexual violence among women in the past 12 months regardless of partnered status

In addition to measuring lifetime experiences of violence, the survey also measured recent experiences of GBV. Recent experiences are defined as experiences of some form of GBV victimisation in the past 12 months (Figure 1).

Overall, 6.1% [95% CI: 5.1-7.3] of women reported that they had experienced physical violence in the past 12 months. This translates to an estimated 1 338 336 women who were physically violated in South Africa in a period of 12 months.

Two percent [2.0%, 95% CI: 1.5-2.5] of women reported that they had experienced sexual violence in the past 12 months. This translates to an estimated 432 525 women who have been sexually violated in the past 12 months. Overall, 7.0% [95% CI: 5.9-8.2] of women reported that they had experienced either physical and/or sexual violence in the past 12 months. This translates to an estimated 1 536 729 women who have either been physically and/or sexually violated in the past 12 months.

Prevalence of violence among intimate partners (IPV)

We present the number of ever-partnered men who reported that they had perpetrated physical and/or sexual violence in their lifetime against their intimate partners in South Africa in 2022. Where applicable, we also provide weighted numbers (Figure 2).

Figure 2: Prevalence of victimisation and perpetration of violence among men aged 18 years and older, South Africa, 2022

Perpetration of intimate partner violence by ever partnered men

Physical
Recent: **2.4%**
366 030 men
Lifetime: **16.7%**
2 495 451 men

Emotional
Recent: **7.2%**
Lifetime: **33.7%**

Sexual
Recent: **2.3%**
284 311 men
Lifetime: **7.5%**
917 395 men

Economic
Recent: **5.3%**
Lifetime: **14.8%**

Physical and/ or Sexual
Recent: **4.0%**
627 939 men
Lifetime: **20.5%**
3 192 790 men

Psychological: Controlling behaviour
Lifetime: **77.2%**

Perpetration towards other men

Sexual
Lifetime: **1.3%**

Victimisation of men during adulthood (Outside the home)

Physical
Recent: **20.4%**

Sexual
Lifetime: **2.3%**

Prevalence of lifetime physical intimate partner violence (IPV) among women

Overall, 22.4% [95% CI: 20.1-24.7] of ever-partnered women reported experiencing physical violence by a partner in their lifetime. This translates to an estimated 3 221 649 ever-partnered women who have experienced physical violence in their lifetime (Figure 1). Lifetime physical IPV was significantly higher among those who were cohabiting with a partner but not married [29.4%, 95% CI: 23.6-35.8] compared to women who were currently married [18.5%, 95% CI: 15.5-22.0]. Factors associated with lifetime physical IPV victimisation and perpetration are presented in Box 1.

Box 1: Factors associated with lifetime physical IPV victimisation among women and perpetration by men

Factors that are significantly associated with lifetime physical victimisation among ever-partnered women	Factors that are associated with lifetime physical perpetration among ever-partnered men
Past relationships: women who had two to three lifetime sexual partners [22.0% CI: 18.6-25.9], and four or more partners/relationships [34.0%, 95% CI: 29.8-38.6] in their lifetime (compared to women with one partner/ relationship in their lifetime)	**Past relationships:** men who had ever engaged in transactional sex [22.3%, 95% CI: 18.7-26.3] or had four or more lifetime sexual partners [18.3%, 95% CI: 16.0-20.8] (compared to one lifetime partner/relationship)
Alcohol and substance use: women who are currently consuming alcohol once or twice a week [33.6%, 95% CI 25.3-43.1], and women with a history of using drugs [45.7%, 95%: 33.3-58.6]	**Alcohol Use:** men who are currently classified as hazardous alcohol drinkers [20.8%, 95% CI: 17.9-24.0]
Poor mental health: women who were found to have mild [30.1%, 95% CI: 26.0-34.4], moderate [33.7%, 95% CI: 25.3-43.3], or severe anxiety [33.6%, 95% CI: 21.2-48.8] in the two weeks prior to the study and those who were found to have minimal [23.0%, 95% CI: 19.1-27.3], mild [26.5%, 95% CI: 22.9-30.4], moderate [37.3%, 95% CI: 29.1-46.3], or severe depression [44.8%, CI: 25.5-65.7] in the two weeks prior to the study, and those who had a lifetime history of suicidal ideation [49.2%, 95% CI: 40.8-57.6]	**Poor mental health:** men who were found to be at risk of clinical depression in the two weeks prior to the study [23.9%, 95% CI: 19.9-28.4], had a lifetime history of suicidal ideation [25.9%, 95% CI: 20.4-32.3], had a history of attempted suicide [31.1%, 95% CI: 21.2-43.0], or had high [30.7%, 95% CI: 26.0-35.8] scores on the current life satisfaction scale
Childhood trauma: women with childhood experiences of physical [28.7%, 95% CI: 25.6-32.0], sexual [47.5%, 95% CI: 32.8-62.7], and emotional abuse [38.2%, 95% CI: 31.2-45.7] and women who reported that their mother was abused by a partner when they were a child [32.4%, 95% CI: 27.5-37.6]	**Childhood trauma:** men who were bullied while growing up [21.9%, 95% CI: 18.4-25.9] or had bullied others [28.3%, 95% CI: 22.6-34.9]
Norms, attitudes and gendered power relations: having low and moderate equitable norms and attitudes related to gender relations [25.9%, 95%CI: 22.5-29.7 and 24.6%, 95% CI: 20.8-28.9] compared to having high equitable norms and attitudes and agreeing to statements on power relations [49.4%, 95% CI: 33.8-65.1]	**Norms, attitudes and gendered power relations:** had high inequitable perceived norms towards gender relations [24.1%, 95% CI: 19.6-29] and high inequitable attitudes towards gendered power relations [23.2%, 95% CI: 19.5-27.3]
Relationship dynamics: women who reported that they had sometimes [25.3%, 95% CI: 21.7-29.3] or often [45.8%, 95% CI: 39.1-52.7] quarrelled with their partners	**Food insecurity:** lived in households that currently experienced food insecurity [22.3%, 95% CI:18.4-26.7]

Prevalence of lifetime physical intimate partner violence (IPV) perpetration by men

Overall, 16.7% [95% CI: 14.8-18.7] of ever-partnered men reported perpetrating physical IPV towards a partner during their lifetime. This translates to an estimated 2 495 451 ever-partnered men who have perpetrated physical IPV (Figure 2). The result shows that perpetration of lifetime physical IPV started early and was significantly higher among 25–34-year-old men [20.5%, 95% CI: 16.4-25.3] and 35–49-year-old men [17.6%, 95% CI: 14.6-21.1] than 18–24-year-old men [9.2%, 95% CI 6.4-13.1]. An analysis by marital status and living arrangements showed similarities to the IPV data for women. Lifetime physical IPV perpetration was higher among men who were cohabiting with a partner but were not married [24.5%, 95% CI: 19.5-30.2], compared to men who had a partner and were not cohabiting [13.9%, 95% CI: 11.3-17.0] and men who were currently married [15.4%, 95% CI: 12.6-18.6]. Differences by locality type were also noted, with prevalence of lifetime physical IPV higher among men residing in rural formal areas [19.7%, 95% CI: 15.3-25.1] and urban areas [18.4%, 95% CI: 16.0-21.1], than men living in rural informal areas [11.6%, 95% CI: 8.9-15.0]. Factors associated with lifetime physical IPV victimisation and perpetration are presented in Box 1.

Prevalence of lifetime sexual intimate partner violence (IPV) among women

Overall, 7.9% [95% CI: 6.5-9.4] of ever-partnered women reported experiencing sexual violence by a partner in their lifetime, this translates to an estimated 1 131 293 ever-partnered women who have experienced sexual IPV in their lifetime (Figure 1). Lifetime sexual IPV was significantly higher among women who were not currently in a relationship [11.1%, 95% CI: 8.4-14.5] than those who were currently married. By locality type, we noted that a higher proportion of women living in urban areas [8.5%, CI: 6.8-10.6] reported sexual IPV than those in rural formal areas. Factors associated with lifetime sexual IPV victimisation and perpetration are presented in Box 2.

Prevalence of lifetime sexual intimate partner violence (IPV) by men

Self-reported perpetration of lifetime sexual IPV was 7.5% [95% CI: 6.2-9.2]. This translates to an estimated 917 395 ever-partnered men who reported perpetrating sexual IPV in their lifetime (Figure 2). Perpetration of sexual IPV was significantly higher among men aged 18 to 24 years [11.1%, 95% CI: 7.7-15.9], 25-34 years [8.8%, 95% CI: 6.3-12.1] and 35-49 years [9.0%, 95% CI: 6.4-12.6] than men aged 50 years and older. Lifetime sexual IPV perpetration was higher among those who had secondary school [8.8%, 95% CI: 7.0-11.0] than those with only primary school education. Factors associated with lifetime sexual IPV victimisation and perpetration are presented in Box 2.

Prevalence of lifetime physical and/or sexual intimate partner violence (IPV) among women

Overall, 23.9% [95% CI: 21.7-26.3] of ever-partnered women reported experiencing physical and/or sexual violence by a partner in their lifetime. This translates to an estimated 3 448 669 ever-partnered women who have experienced physical and/or sexual violence in their lifetime (Figure 1). The experience of physical and/or sexual violence was significantly higher among Black African women [26.0%, 95% CI: 23.5-28.6] than those of other race groups. As observed with physical and sexual IPV, physical and/or sexual violence was higher among women who were cohabiting with a partner but not married [30.6%, 95% CI: 24.9-37.1] than for those who were currently married. Factors associated with lifetime physical and/or sexual IPV victimisation and perpetration are presented in Box 3.

Box 2: Factors associated with lifetime sexual IPV victimisation among women and perpetration by men

Factors that are significantly associated with lifetime sexual victimisation among ever-partnered women	Factors that are associated with lifetime sexual perpetration among ever-partnered men
Past sexual relationships: women who had two to three [8.0%, 95% CI: 6.0-10.5] or four or more [12.0%, 95% CI: 9.1-15.7] lifetime sexual partners (compared to one lifetime partner/relationship)	**Past sexual relationships:** men who had ever engaged in transactional sex [17.8%, 95%CI: 13.8-22.6]
Alcohol and substance use: women drinking alcohol every day [22.6, 95% CI: 10.7-41.5] or who had ever used drugs [20.1%, 95% CI: 11.2-33.4]	**Alcohol and substance use:** currently hazardous alcohol drinkers [10.8%, 95%CI: 8.5-13.7] or used drugs in the past 12 months [16.3%, 95% CI: 10.1-25.3]
Poor mental health: having mild [11.3, 95% CI: 8.6-14.9], moderate [14.3, 95% CI: 7.7-25.0], or severe [23.6, 95% CI: 12.2-40.7] anxiety, or mild [11.3%, 95% CI: 8.7-14.6], moderate [15.6%, 95% CI: 9.3-24.8], or severe depression [27.9%, 95% CI: 10.8-55.2] in the past two weeks, and having a history of suicidal ideation [21.4%, 95% CI: 14.2-30.9]	**Poor mental health:** had a history of attempted suicide [15.9%, 95% CI: 8.9-26.8], were currently at risk of clinical depression [13.6%, 95% CI: 9.7-18.9], or had lower empathy scores [18.0%, 95% CI: 11.5-26.8]
Experiences of childhood trauma: having a history of physical [9.9%, 95% CI: 7.8-12.4], sexual [23.6%, 95% CI: 12.6-39.7], and/or emotional [17.2%, 95% CI: 11.9-24.3] abuse before the age of 15 years, or reported that their mother experienced physical abuse from a partner when they were a child [12.9%, 95% CI: 9.6-17.2]	**Experiences of childhood trauma:** had high childhood trauma scores [15.4%, 95%CI: 12.1-19.4], and/or had bullied others while growing up [14.3%, 95% CI: 10.4-19.4]
Relationship dynamic: reported often quarrelling with their partner [22.6%, 95% CI: 17.3-28.9]	

Box 3: Factors associated with lifetime physical and/or sexual IPV victimisation among women and perpetration by men

Factors that are significantly associated with lifetime physical and/ or sexual victimisation among ever-partnered women	Factors that are associated with lifetime physical and/ or sexual perpetration among ever-partnered men
Past sexual relationships: women who had two to three lifetime sexual partners [23.4%, 95% CI: 19.9-27.3] and four and more sexual life partners [36.9%, 95% CI: 32.6-41.4] in their lifetime (compared to one lifetime partner/ relationship)	**Past sexual relationships:** a history of engaging in transactional sex [28.6%, 95% CI: 24.7-32.8], men who had had four or more sexual life partners or relationship in their lifetime [22.5%, 95% CI: 20.1-25.1] (compared to one lifetime partner/relationship)
Alcohol use and substance use: women who currently consumed alcohol once or twice a week [35.1%, 95% CI: 26.7-44.6] or every day [37.9%, 95% CI: 24.7-53.2], and had a history of drug use [50.4%, 95% CI: 37.7-63.1]	**Alcohol use:** men who were classified as currently hazardous alcohol drinkers [25.9%, 95% CI: 22.8-29.2]
Poor mental health: women who had mild [31.7%, 95% CI: 27.5-36.2], moderate [37.0%, 95% CI: 28.4-46.5], or severe anxiety [36.8%, 95% CI: 23.9-51.9], reported minimal [24.1%, 95% CI: 20.2-28.4, mild [28.7%, 95% CI: 24.9-32.9], moderate [39.3%, 95% CI: 31.1-48.2], or severe depression [45.9%, 85% CI: 26.6-66.5] in the past two weeks, or had ever had suicidal ideation [52.4%, 95% CI: 44.5-60.2]	**Poor mental health:** men who were currently at risk of clinical depression [30.3%, 95% CI: 25.9-35.0], had a history of suicidal ideation [29.5%, 95% CI: 23.8-36.0], had a history of attempted suicide [35.8%, 95% CI: 25.8-47.1], or men who scored lower on the current life satisfaction scale [24.5%, 95% CI: 21.0-28.3]
Childhood trauma: women who reported childhood physical [30.4%, 95% CI: 27.2-33.7], sexual [56.2%, 95% CI: 41.7-69.7], and/or emotional abuse [40.1%, 95% CI: 33.0-47.5] before age 15, or women who reported that their mother experienced physical abuse from a partner when they were a child [34.3%, 95% CI: 29.4-39.6]	**Childhood trauma:** men who had medium [22.1%, 95% CI: 18.1-26.7] or high scores [37.3%, 95% CI: 32.5-42.3] for childhood trauma (compared to low scores), were bullied while growing up [26.3% CI: 22.6-30.4], or had bullied others [35.0%, 95% CI: 29.1-41.5]
Norms, attitudes and gendered power relations: women who held low [27.6%, 95% CI: 24.2-31.3] or moderate [26.1%, 95% CI: 22.3-30.4] equitable attitudes and perceived norms related to gender relations compared to high equitable attitudes and perceived norms, or had agreed to statements on gendered power relations [49.4%, 95% CI: 33.8-65.1]	**Norms, attitudes and gendered power relations:** men who had high inequitable norms and attitudes about gender relations [27.7%, 95% CI: 23.1-32.9] (compared to low inequitable norms and attitudes) or men who had high inequitable attitudes towards gendered power relations [28.0%, 95% CI: 24.1-32.4]
Relationship dynamic: women who reported sometimes [27.4%, 95% CI: 23.7-31.4] or often [48.6%, 95% CI: 41.8-55.5] quarrelling with their partner	**Food insecurity:** men who lived in households that experienced food insecurity at times [26.4%, 95% CI: 22.3-30.9]

Prevalence of lifetime physical and/or sexual intimate partner violence (IPV) perpetration by men

Self-reported lifetime perpetration of physical and/or sexual IPV was 20.5% [95% CI: 18.5-22.6]. This translates to an estimated 3 192 790 ever-partnered men who have physically and/or sexually violated a partner (Figure 2). The perpetration of physical and/or sexual violence was significantly higher among ever-partnered men in urban areas [22.3%, 95% CI: 19.7-25.1] than those in rural informal areas. Factors associated with lifetime physical and/or sexual IPV victimisation and perpetration are presented in Box 3.

Prevalence of physical and sexual IPV among ever-partnered women and men in the past 12 months

In Figure 1 we present the proportions of ever-partnered women who experienced recent (defined as the past 12 months) physical and/or sexual violence by their intimate partners. Figure 2 shows proportions for men who had perpetrated physical and/or sexual violence against their intimate partners in the previous 12 months. These were presented with weighted numbers where applicable.

Prevalence of IPV victimisation among ever-partnered women in the past 12 months

Overall, 5.2% [95% CI: 4.2-6.3] of ever-partnered women reported experiencing physical IPV by a partner in the past 12 months. This translates to an estimated 747 188 women who have experienced physical IPV. With regard to sexual IPV, 2.5% [95% CI: 1.9-3.2] women reported that they had experienced sexual IPV by a partner in previous 12 months. This translates to an estimated 354 196 women who reported sexual IPV. Overall, 6.4% [95% CI: 5.4-7.7] of women reported having recently experienced either physical and/or sexual IPV. This translates to an estimated 925 261 women who have experienced physical and/or sexual violence by an intimate partner in the previous year.

Prevalence of perpetration of IPV by ever-partnered men in the past 12 months

Overall, 2.4% [95% CI: 1.7-3.5] of men reported that they perpetrated physical IPV against a partner recently. This translates to an estimated 366 030 men who reported that they had physically violated a partner in the past 12 months. Overall, 2.3% [95% CI: 1.7-3.2] of men reported that they had perpetrated sexual IPV against a partner in the past 12 months. This translates to an estimated 284 311 men who self-reported violating their partner sexually. Overall, 4.0% [95% CI: 3.2-5.1] of men reported that they had recently perpetrated physical and/or sexual IPV, which translates to 627 939 men having violated a partner.

Prevalence of lifetime emotional abuse among intimate partners

Overall, 25.1% [95% CI: 22.8-27.5] of ever-partnered women were found to have experienced one or more acts of emotional abuse in their lifetime (Figure 1). Experiences of one or more acts of emotional abuse were significantly higher among women aged 25–34 years [29.9%, 95% CI: 25.1-35.1] than for those aged 50 years and older [20.2%, 95% CI: 17.4-23.4].

The perpetration of one or more acts of emotional abuse was 33.6% [95% CI: 31.0-36.3] among ever-partnered men (Figure 2). This was significantly higher among men aged 25–34 years [39.0, 95% CI: 34.1-44.3] than those aged 50 years and older [27.9%, 95% CI: 23.8-32.5]. The perpetration of one or more acts of emotional abuse was also significantly higher among men who were cohabiting with a partner and not married [42.8%, 95% CI: 36.4-49.6] than for men who were currently married [29.0%, 95% CI: 25.3-33.0].

Prevalence of lifetime economic abuse between intimate partners

Overall, 13.1% [95% CI: 11.2-15.1] of ever-partnered women had experienced one or more acts of economic abuse in their lifetime (Figure 1). Reports of experiences of one or more acts of economic abuse were significantly higher among Black African women [14.8%, 95% CI: 12.6-17.4] than for women of other race groups [7.7%, 95% CI: 5.6-10.6]. It was also higher among women who were not currently in a relationship [19.9%, 95% CI: 16.0-24.5] than women who were currently married [9.3%, 95% CI: 7.4-11.5].

Reports of perpetration of one or more acts of economic abuse reported by ever-partnered men were considerably high at 14.8% [95% CI: 13.0-16.8] (Figure 2). Perpetration of economic abuse was significantly higher among men aged 25–34 years [21.3%, 95% CI: 17.2-26.1] than all other age groups, higher for Black African men [16.4%, 95% CI: 14.2-18.8] than other race groups [8.5%, 95% CI: 5.8-12.3] , and also higher for those who were cohabiting and not married [19.0%, 95% CI: 14.8-24.1] than men who were currently married [11.4%, 95% CI: 9.4-13.8].

Prevalence of controlling behaviour among intimate partners

Overall, 57.6% [95% CI: 54.4-60.7] of ever-partnered women reported that they had experienced controlling behaviours from a partner (Figure 1). This was significantly higher among younger women aged 18–24 [76.2%, 95% CI: 68.4-82.5], 25–34 [62.7%, 95% CI: 56.1–68.8] and 35–49 [57.9%, 95% CI: 53.1-62.7] than for their counterparts aged 50 years and older [45.9%, 95% CI: 41.3-50.5]. As with other forms of IPV, Black African women [64.7%, 95% CI: 61.6-67.7] were more affected by psychological abuse than women from other race groups [33.1%, 95% CI: 26.9-40.1]. Furthermore, when data was analysed by marital status and living arrangements, it was observed that women who had a partner but were not cohabiting [72.1%, 95% CI: 66.3-77.2], women who were not currently in a relationship [64.6%, CI: 59.2-69.7], and women who were cohabiting and not married [63.2%, 95% CI: 55.8-69.9] had higher prevalence of economic abuse than women who were currently married [44.4%, 95% CI: 40.1-48.8]. Women who resided in rural informal (tribal) areas [65.9%, 95% CI: 60.4-71.0] were more affected by controlling behaviour than women residing in urban areas [54.8%, 95% CI: 50.9-58.7].

There was high agreement with one or more statements measuring controlling behaviour among men who had ever had a partner (77.2% [95% CI: 74.7-79.4]) (Figure 2). Controlling behaviour was significantly higher among men aged 18–24 [80.2%, 95% CI: 74.2-85.1], 25–34 [81.2%, CI: 76.5-85.2] and 35–49 years [78.4%, 95% CI: 74.4-82.0] than their counterparts aged 50 years and older [70.1%, 95% CI: 65.9-74.0]. It was also higher among Black African men [79.7%, 95% CI: 77.3-81.9] than men from other race groups [66.6%, 95% CI: 59.3-73.1] and men who had a partner and were not cohabiting [80.1%, 95% CI: 76.7-83.2] than for men who were currently married [72.5%, 95% CI: 68.3-76.3].

Prevalence of IPV-related Injuries among women

Overall, 41.6% [95% CI: 35.9-47.5] of women who ever experienced physical or sexual violence by an intimate partner reported being injured as a result of IPV. Of these women, 38.8% reported being injured once, 35.6% two to five times, and 25.7% more than five times.

Disclosure and help-seeking behaviour among women who have experienced IPV

Of women who had experienced IPV, 64.2%, (95% CI: 58.9-69.1) reported that they told their family about their experience of violence, while 23.1% (95% CI: 18.9-27.8) of women indicated that they did not disclose their experiences to anyone. In terms of seeking assistance for victimisation, 30.7% (95% CI: 25.5-36.3) reported that they visited the police, followed by hospitals or health centres (21.6%, 95% CI: 17.2-26.6). Some women reported that they consulted a religious leader (7.8%, 95% CI: 5.0-11.8) and social services (6.2%, 95% CI: 4.0-9.6).

Prevalence of non-partner physical and sexual violence since age 15

Figure 1 presents the proportion of women who reported experiences of physical and/or sexual violence by a non-partner since the age of 15 years. Where applicable, weighted numbers are also provided.

Prevalence of lifetime non-partner physical violence since age 15

Overall, 24.6% [95% CI: 22.5-26.8] of women reported experiencing physical violence by a non-partner since the age of 15 years. This translates to an estimated 5 417 522 women who have experienced lifetime physical violence by a non-partner since age 15 years (Figure 1). Non-partner violence was significantly higher among women aged 18–24 [31.2%, 95% CI 26.0-37.0], 25-34 [27.1%, 95% CI 23.5-31.1] and 35-49 years [25.2%, 95% CI 22.1-28.7] compared to those aged 50 years and older [18.2%, 95% CI:15.6-21.0]. As was observed previously, Black African women [26.8%, 95% CI: 24.4-29.3] were more affected than women of other race groups [15.9%,95% CI: 12.7-19.9]. Non-partner physical violence was also higher among women who were cohabiting and not married [31.3%, 95% CI: 25.4-37.9], women who had a partner and were not cohabiting [30.8%, 95% CI: 26.5-35.5] and women who were not currently in a relationship [24.3%, 95% CI: 21.2-27.7] than their married counterparts [17.6%, 95% CI: 15.1-20.3]. Family members were the most frequently identified perpetrators of lifetime non-partnered physical violence [31.1%, 95% CI: 27.1-35.3] followed by friends and acquaintances [11.7%, 95% CI: 9.1-15.0] and strangers [1.8%, 95% CI: 1.1-2.9].

Prevalence of lifetime non-partner sexual violence since age 15

The study found that 5.9% [95% CI: 5.0-6.9] of women had been sexually assaulted by a non-partner in their lifetime. This translates to an estimated 1 278 011 women who experienced sexual violence by a non-partner (Figure 1). Experiences of lifetime sexual violence by a non-partner were significantly higher among women who were cohabiting but not married [9.6%, 95% CI: 6.5-13.9] than married women [4.5%, 95% CI: 3.4-6.0].

Prevalence of lifetime non-partner physical and/or sexual violence since age 15

Overall, 27.0% [95% CI: 24.8-29.3] of women reported experiencing physical and/or sexual violence since the age of 15. This translates to an estimated 5 948 915 women who experienced physical and/or sexual violence by a non-partner (Figure 1). Lifetime physical and/or sexual violence by a non-partner was significantly higher among women aged 18–24 [34.0%, 95% CI: 28.6-39.9], 25–34 [29.5%, 95% CI: 25.8-33.4] and 35–49 years [27.8%, 95% CI: 24.5-31.3] than for women aged 50 years and older (20.1%, 95% CI: 17.6-23.0]. Black African women [29.1%, 95% CI: 26.6-31.7] were more affected by physical and/or sexual violence than women of other race groups [18.5%, 95% CI: 15.0-22.7]. Prevalence was highest among women who were cohabiting and not married [36.2%, 95% CI: 30.1-42.8], women who had a partner and were not cohabiting [33.3%, 95% CI: 28.9-38.0] and among women who were not currently in a relationship [26.4%, 95% CI: 23.2-29.9], than married women [19.5%, 95% CI: 16.9-22.4].

Prevalence of non-partner violence among all women in the past 12 months

In Figure 1 proportions of women who experienced recent non-partner physical, sexual and physical and/or sexual violence are presented. Where applicable, weighted numbers are also provided.

Overall, 3.4% [95% CI: 2.5-4.4] of women reported experiencing physical violence by a non-partner in the past 12 months. This translates to an estimated 738 407 women who were violated by a non-partner. Among all women, 0.6% [95% CI: 0.4-0.9], reported that they had experienced sexual violence by a non-partner in the past 12 months. This translates to an estimated 124 438 women who were sexually assaulted recently. Overall, 3.7% [95% CI: 2.8-4.7] of women had recently experienced either physical and/or sexual violence by a non-partner, which translates to an estimated 807 260 women.

Prevalence of GBV victimisation among women with a disability

Overall, 7.7% [95% CI: 6.8-8.7] of women aged 18 years and older had a disability. Compared to women with no disabilities, a higher proportion of ever-partnered women with a disability had experienced physical violence (29.3% [95% CI: 23.4-36.0] vs 21.7% [95% CI: 19.4-24.2]), physical and/or sexual violence (31.2% [95% CI: 25.2-38.0] vs 23.2% [95% CI: 20.9-25.7]), emotional abuse (31.9% [95% CI: 25.7-38.7] vs 24.4% [95% CI: 22.1-26.9]), economic abuse (16.3% [95% CI: 12.0-21.7] vs 12.8% [95% CI: 10.9-14.9]), and/or controlling behaviour (60.0% [95% CI: 50.5-68.8] vs 57.4% [95% CI: 54.1-60.6]) by a partner in their lifetime. The prevalence of sexual violence by a partner was twice as high, 14.6% [95% CI: 10.1-20.6] vs 7.2% [95% CI: 5.9-8.8] for ever-partnered women living with a disability than for those who did not report a disability. With regard to the prevalence of recent forms of IPV, there were no significant differences observed between ever-partnered women with a disability and women without a disability for recent physical violence which was 4.3% [95% CI: 2.2-8.3] vs 5.3% [95% CI: 4.3-6.5], sexual violence was 3.6% [95% CI: 1.8-7.3] vs 2.4% [95% CI: 1.8-3.1], physical and/or sexual violence was 6.9% [95% CI: 4.0-11.5] vs 6.4% [95% CI: 5.3-7.7], emotional abuse was 9.6% [95% CI: 6.4-14.2] vs 10.1% [95% CI: 8.6-11.8]) and economic abuse was 4.4% [95% CI: 2.6-7.4] vs 4.5% [95% CI: 3.5-5.7] respectively.

Prevalence of violence during the COVID-19 lockdown period

A low proportion of women reported experiencing violence during the COVID-19 lockdown period, with the perpetrators mostly being their partners. Overall, 1.8% [95% CI: 1.4-2.3] of women reported experiencing physical violence, 0.9% [95% CI: 0.6-1.3] experienced sexual violence, and 2.7% [95% CI: 2.2-3.3] experienced emotional abuse by their partner or ex-partner. Self-reported physical violence perpetration by men towards a partner was 1.1% [95% CI: 0.7-1.6], sexual violence was 0.8% [95% CI: 0.5-1.3] and emotional abuse was 1.9% [95% CI: 1.4-2.6]. These findings should be understood as reflecting a specific point in time during which other factors that are not measured in the study were also at play (e.g., restricted movement, lock-down levels, alcohol sale prohibitions, etc.) and therefore these estimates should not be compared to recent or lifetime experiences of physical and sexual IPV.

Norms, attitudes, and gender-power relations amongst women and men

Regarding gender norms, a large proportion of ever-partnered women [59.6%, 95% CI: 57.1-62.1] agreed that a woman's most important role is to take care of her home and cook for her family. Over half of the sample [53.8%, 95% CI: 51.3-56.2] agreed that it is a woman's responsibility to avoid getting pregnant, while 48.0% [95% CI: 45.6-50.3] agreed that men need sex more than women, with 30.3% [95% CI: 28.1-32.6] indicating that they believed that a person needs to be tough to be a man.

When men were presented with statements that were designed to measure gendered norms, attitudes and gendered power relations, a large proportion of ever-partnered men, 66.6% [95% CI 63.9-69.1] agreed that a woman's most important role is to take care of her home and cook for her family, followed by 54.4% [95% CI: 51.7-57.0] who agreed that men need to be tough, and 51.6% [95% CI: 49.0-54.2] who agreed that men need sex more than women. About 10.7% [95% CI: 9.3-12.3] of men believed that a woman should tolerate violence in order to keep her family together, 8.3% [95% CI: 7.1-9.6] believed that there are times when a woman deserves to be beaten, and 30.6% [95% CI: 28.2-33.1] believed that men should defend their reputation with force if they have to (for example, if they have been insulted).

Regarding attitudes towards gendered power relations, 13.3% [95% CI: 11.8-14.8] of ever-partnered women agreed that a man who has paid the bride price for his wife, owns her, and 9.2% [95% CI: 8.0-10.6] of ever-partnered women believed that if a man has paid *lobola* for his wife, she must have sex with him whenever he wants, and 9.1% [95% CI: 7.9-10.4] agreed with a statement that if a wife does something wrong, her husband has the right to punish her.

The majority of ever-partnered men [69.5%, 95% CI: 66.8-72.1] believed that a woman should obey her husband. A further 37.5% [95% CI: 34.9-40.1] of men believed that a man should have the final word in all family matters, followed by 31.5% [95% CI: 29.1-34.0] of men who believed that it would be shameful to have a gay son, and 22.5% [95% CI: 20.5-24.7] believed that a woman cannot refuse to have sex with her husband.

Men's awareness and perceptions of laws about violence against women in South Africa

Men were asked additional questions regarding their awareness of GBV laws. The majority of men [84.8%, 95% CI: 82.9-86.5] were aware that there were laws in South Africa that addressed violence against women. Most men [84.0%, 95% CI: 81.8-86.0] were aware that a husband who forces his wife to have sex against her will, is committing a criminal act. A high proportion of men agreed with the perception that the laws make 'it too easy for a woman to bring a violence charge against a man' [73.9%, 95% CI: 71.6-76.1]. Although awareness of laws was high, the responses to questions about gendered power relations showed that 9.9% of ever-partnered men held the view that women who were raped are usually to blame for putting themselves in that situation. A further 11.9% agreed that, if a woman does not physically fight back, it is not rape. The data also show that 15.0% of ever-partnered men agreed that if a wife does something wrong her husband has a right to punish her, and 22.5% believed that a woman could not refuse to have sex with her husband.

Concluding remarks

The survey findings reveal the troubling picture of GBV in South Africa, highlighting its widespread and severe nature. It highlights that a substantial proportion of women aged 18 years and older have experienced physical violence at some point in their lives, with significant differences observed based on race and relationship status. Sexual violence is also a major concern, having affected nearly one in ten women across the country. The study highlights that different forms of violence often start early, affecting pre-adolescent girls and boys, young women and men, and adults. The prevalence of recent victimisation and perpetration of violence among adults 50 years and older, underscores the importance of a life course approach to preventing GBV. The study confirmed that exposure to childhood trauma plays a pivotal role in both the victimisation of women and the perpetration by men, and that women exposed to domestic violence as children had a higher prevalence of victimisation. The high rates of violence experienced by women, with even higher rates experienced by women with a disability, underscores the urgent need for government, professionals, and service providers to play a crucial role in identifying women affected by GBV, and to ensure that women with disabilities are included in prevention plans. There is also an urgent need to address the actions of men who perpetrate such violence, as well as the factors driving these behaviours. The study results reflect the pervasive issue of male perpetration, indicating that the violence women endure is a direct consequence of the actions of some men.

IPV was found to be notably high, with a considerable number of ever-partnered women reporting lifetime physical violence from a partner. This was found to be particularly prevalent among women who were cohabiting but not married. A significant number of men reported having perpetrated physical or sexual IPV in their lifetime, with higher rates observed among men residing in urban areas. Findings on recent experiences of IPV show that a notable proportion of women experienced physical IPV, and a significant proportion has experienced sexual IPV. Non-partner physical violence was found to be high, especially among younger and Black African women. Key factors that were found to be linked to a higher prevalence of IPV among women included the number of lifetime sexual partners, substance abuse, poor mental health, childhood trauma, and inequitable gender norms. For men, factors influencing IPV perpetration include hazardous alcohol consumption, having engaged in transactional sex, poor mental health, childhood trauma, and inequitable attitudes toward gender relations, with food insecurity also playing a role.

The persistently high rates of GBV victimisation and perpetration, despite existing legislative frameworks and policies, suggest the need for a comprehensive approach that does not only address the immediate instances of violence but also includes a focus on women with disabilities and tackles the underlying structural and systemic factors. Addressing cultural and legal dimensions is essential for fostering a just and equitable society in which gender norms do not perpetuate violence and inequality. The high rates of GBV experienced by Black African women especially, point to a need to work with their partners to tackle the historical trauma and social injustices that continue to affect these communities. Decolonising GBV in South Africa, through a multifaceted approach that addresses the deeply entrenched colonial legacies influencing societal attitudes and systemic structures, is important. Alternative decolonial models of GBV prevention also situate both women and men in community-centred interventions that focus on the spirit of ubuntu as a catalyst for healing and justice.

About a quarter of women reported experiencing emotional abuse in their lifetimes, while over a third of men admitted to perpetrating it. Economic abuse was also widespread, affecting a significant number of women. In addition, more than half of women reported experiencing controlling behaviour from a partner, and a substantial proportion of men, particularly younger Black African men, reported engaging in such behaviour. The data reveals deeply ingrained gender norms and power dynamics, with strong cultural reinforcement of traditional gender roles and a troubling acceptance of male aggression and dominance. Disturbingly, some men justified violence in certain circumstances and perceived laws as overly lenient toward women. This highlights a clear disconnect between legal knowledge and attitudes toward gender-based violence.

These findings underscore the urgent need to tackle the root social and cultural factors that drive GBV and to bolster support systems for survivors. Strengthening policymaking and community interventions is essential for effectively addressing GBV. Future research should further explore the complexities of GBV to develop more effective prevention and intervention strategies. It is also important to recognise that individuals who have experienced or witnessed violence and abuse may be more likely to replicate these behaviours, with historical and intergenerational trauma playing a significant role in shaping such patterns.

This report concludes by acknowledging the significant progress and innovation achieved by the government, civil society organisations, implementers, academics, researchers, and funders in addressing the GBV epidemic in South Africa. Moving forward, it is crucial to emphasise that continued collaboration and partnerships across all sectors are vital for effectively combating GBV to ensure sustained progress.

Recommendations and policy Implications

The findings of this study provide insights into GBV and highlight the necessity for developing targeted and comprehensive strategies to address GBV in South Africa. It also provides an opportunity to recalibrate the GBVF response, identify gaps and strengthen existing interventions that are outlined under the work of different pillars within the National Strategic Plan on GBVF (NSP on GBVF). The results of the study should be anchored within the NSP on GBVF with each government department and its stakeholders using the findings to take stock of where we are as a country with regard to the work outlined in the plan.

The current recommendations should be supplemented with carefully crafted evidence-based plans of action that are clearly owned by lead government departments and stakeholders who must be tasked with the role of implementing the recommendations. We propose that the Presidency, working with the Department of Women, Youth, and Persons with Disabilities (DWYPD) and Civil Society, be tasked with the role of leading this process. Each department should be tasked with developing a set of agreed-upon, actionable, costed, evidence-based action plans that are informed by the study results.

The recommendations are partly framed using the WHO's RESPECT framework[1] for GBV Prevention, which provides a comprehensive guideline for designing appropriate interventions that can address all levels of the socio-ecological model (societal, communal, interpersonal and individual levels). We also drew from the UN's Essential services package for women and girls subjected to violence, which prescribes international standards based on global evidence about what works best to address violence against women and girls (VAWG). Lastly, we consulted GBV experts who peer-reviewed the report to also review the recommendations with an aim of identifying gaps and strengthening them.

We recommend that interventions be implemented at individual, interpersonal, community, and societal levels. This approach can help to address the complex nature of GBV and improve prevention efforts across society. A collaborative approach involving various stakeholders, including government departments and other organisations, is crucial for effective implementation (see Appendix D).

Critical stakeholders for addressing the recommendations coming from this study include the Presidency, the future GBVF Council, the Department of Women, Youth and Persons with Disabilities, all other relevant government departments, and different spheres of government:

- **social, health and mental health services** to coordinate support services and focus on enhancing interventions for substance use, mental health, and gender-affirming care.
- **child protection and family support** to focus on early detection of childhood exposure to violence, provide family support programmes, and address intergenerational trauma.
- **educational and community-based interventions** to advance gender equality education, promote healthy relationships, and conduct community education workshops.
- **legal and law enforcement services** to work on enforcing domestic violence laws and strengthening legal frameworks.
- **research and policy development** to develop social policies, design long-term strategies to address and develop intersectionality-informed and culturally relevant interventions, and design comprehensive approaches for GBV prevention.
- **economic cluster, treasury, donors and developmental partners** to support the intersectionality-informed sector and community-based interventions that are required to address GBV and reduce incidence, and to support prevention programmes, including care and support services and GBV research across the country.

1. The frame work is grounded in global evidence and recommends seven strategies that are summarised in the acronym RESPECT: 1) Relationship skills strengthened; 2) Empowerment of women; 3) Services ensured 4) Poverty reduced; 5) Environments made safe; 6) Child and adolescent abuse prevented and 7) Transformed attitudes, beliefs, and norms.

Individual-level interventions

The study found that associated risks for victimisation and perpetration of IPV included mental health challenges, (particularly among men), lack of condom use, number of lifetime sexual partners, substance use, food insecurity, and childhood trauma, which includes witnessing domestic violence and for men being bullied or bullying others. The study also points to a crisis of mental health especially among men.

Suggested interventions include:

Addressing psychological and socio-behavioural factors:

- In light of the observed mental health crisis among men that impacts the perpetration of violence against women and the long-term impact GBV has on men and women's mental health, we recommend that the Department of Health urgently undertakes a review of the mental health services available, with the view to strengthening services, particularly for survivors of GBV, children who have witnessed GBV, and men.
- Integrate SRH&R services with GBV services to strengthen early detection of GBV cases and the implementation of risk reduction interventions aimed at curbing associated risky sexual behaviours, STIs, and substance use.

Implementing early learning and prevention initiatives:

- Interventions and programmes to prevent child abuse should include boys and girls. Implement early detection and empathetic responses to childhood experience of violence and bullying as a means to prevent perpetration of GBV later in life. Services for child survivors should be made equally accessible to boys and girls. This requires an investment in responsive and child-friendly protection systems and services that are more easily accessible to children and their caregivers.
- Implement robust child rights-focused programmes in schools to ensure that children who are victims of sexual abuse understand that their experiences are unacceptable. This programme should educate children about their rights, provide clear information on where to seek support, and assure children that the assistance they receive will be accessible, dependable and confidential.
- Create and integrate age-specific, evidence-based anti-violence programmes and training for children, youth, persons with disabilities, and adults to address high rates of GBV with a special focus on, child abuse, bullying, physical and sexual violence, emotional and economic abuse, and controlling behaviour.
- Develop evidence-based interventions aimed at shifting perceptions and promote gender equality by developing comprehensive learning programmes among young and older individuals on gender equality, the importance of mutual consent, and building healthy relationships that are pleasurable for both parties.
- Given the findings on harmful beliefs, controlling behaviour, and gendered power dynamics affecting both men and women, we recommend developing a comprehensive, age-appropriate government communication strategy. This strategy should aim to challenge and change these beliefs and norms by addressing socialisation processes and promoting unlearning and re-learning.

Interpersonal-level interventions

The study found that women were more dependent on grants as a main source of income while men were more likely to be employed, and their salary or wages was reported as the main source of income. This underscores the extent that women's dependency on other sources of income for survival is likely to be a risk factor for economic abuse and controlling behaviour. The study found that most of the physical violence that is perpetrated by a non-partner happens in the family or is perpetrated by a family member.

Suggested interventions include:

Economic empowerment and support through:

- implementing gender-transformative and economic empowerment interventions to improve the economic status and stability of women and their families, and addressing economic abuse by implementing interventions that are aimed at enhancing the overall livelihoods of both men and women, with a special focus on youth and women with disabilities.

Strengthening family interventions by:

- increasing investment in evidence-based family support programmes to prevent and address violence and tolerance for violence within the home environment.
- advocating for enforcement of domestic violence laws to protect victims/survivors and expedite legal processes for granting of protection orders (including safe houses and shelters for women and children).
- ensuring that the law and GBV services are accessible to all women, especially youth and women with disabilities.
- expanding evidence-based family-strengthening interventions that address intergenerational trauma, child welfare, family safety, incorporating positive parenting and other evidence-based strategies to heal the family.

Community-level interventions

The study found a strong correlation between holding inequitable gender norms and the perpetration of intimate partner violence (IPV).

Suggested interventions include:

Transforming gender norms and attitudes by:

- designing and implementing evidence-based, culturally relevant, community-based, tailored interventions focussed on changing harmful gender norms and attitudes (un-learning and re-learning).
- using community activism to change harmful gendered power relations and stereotypes through evidence-informed community-based interventions that educate youth, men and women about healthy, consensual relationships.
- emphasising the importance of healing from childhood trauma, mental health and seeking care.
- investing in evidence-informed programmes that promote gender-equitable relationships and transforming traditional gender roles.
- developing an evidence-informed government-wide communication strategy to shift harmful societal beliefs and norms regarding gender and GBV.
- training and engaging community leaders to transform societal attitudes that normalise psychological, economic and emotional abuse and work with communities to advocate for policies that highlight its seriousness, ensuring it is integrated into existing domestic violence frameworks.

Societal-level interventions

The study found that the most sought-after service after experiencing GBV was law enforcement followed by hospitals or health centres. Most women disclosed to their families and some to religious leaders.

Suggested interventions include:

improving support services and coordination by:

- enhancing coordination of information (shared data) and referrals among police, justice, social, and health services to provide comprehensive support for GBV victims/survivors, child witnesses, survivors with disabilities, and families and link perpetrators to appropriate interventions to address GBV perpetration.
- increasing access to quality GBV services for those who are not able to access one-stop care centres like Thuthuzela Care Centres.
- investment in existing service providers to widely and systematically increase their capacity to deal with GBV by adopting clear referral pathways and information sharing protocols – this can make a bigger stride for all victims/survivors, especially those with disabilities and those in hard-to-reach areas of the country.
- ensuring privacy and safety during routine health screenings especially for women with disabilities, offering gender-affirming care, and delivering high-quality mental health services tailored to survivors' needs.
- collaborating with local women's rights organisations, families and GBV-sensitised religious organisations to support victims/survivors and ensure they receive the necessary assistance.

Despite heightened awareness of GBV laws among men, the reported rates of perpetration suggest a gap between what some men know and practice. Therefore, additional interventions could include:

Enhancing the monitoring and assessment of GBV laws by:

- strengthening mechanisms for holding GBV perpetrators accountable and ensuring that these accountability mechanisms are not only punitive but are also designed to achieve changes in attitude and behaviour, rehabilitation, and healing.
- engaging national and civil society stakeholders to conduct impact assessments of GBV laws to identify implementation gaps.
- increasing collaboration with both formal and traditional legal systems to overcome barriers to the effective implementation and enforcement of GBV laws.

A call for long-term and holistic approaches

The high level of victimisation and perpetration of GBV observed among Black communities requires that key stakeholders tackle the difficult conversation about the historical impact of state-sponsored violence and the brutality of apartheid in our communities. The study highlights the complexity of GBV and the need for interventions that use an intersectional approach to address the colonial, relational and structural aspects of GBV. This must include addressing intergenerational trauma, effects of racism, and social injustices.

Given the scale of the challenge, it is important to harness existing capacity, while also building capacity to work towards eradicating GBV. Pillar 2 of the NSP on GBVF suggests capacity building through engagement with community development workers and community health care workers. These ideas for localising and extending the reach of prevention interventions should be piloted as part of the response. The NSP on GBVF also recommends that implementation of GBV prevention be integrated into programmes that address related social issues – specifically alcohol abuse, HIV prevention, and economic empowerment of women, youth, persons with disabilities and LGBTQIA+ individuals.

Suggested interventions include:

Government and research strategies to eradicate GBV:

- adopting a long-term, culturally relevant approach to GBV eradication, focusing on household, family and community environments.
- focusing on the different leadership layers in communities, particularly traditional communities, and linking GBV messaging to rebuilding social fabric, strengthening community and families, and raising young people that can actively reshape communities, families and society at large.
- developing appropriate social policies to address the social and structural drivers that were identified in the study.
- designing and evaluating interventions from an intersectionality-informed approach and culturally appropriate perspective, addressing the historical violence and disempowerment of women and Black communities in general
- commissioning organisations such as the Healing of the Memories Institute, the Trauma Centre for Survivors of Violence and Torture, and intergenerational trauma experts to develop evidence-based, community-based interventions that draw from the idea of Ubuntu Circles of healing as articulated in the NSP on GBVF (2.6.2., p 94) to provide safety nets to foster healing and addressing historical trauma in a community-centred way.

CHAPTER 1

BACKGROUND

1.1. Introduction

Gender-based violence (GBV) in South Africa and globally remains a multifaceted, pervasive, historical, political, social, economic, cultural, legal, and public health issue. GBV occurs within a historical context of colonial and apartheid violence that continues to be reproduced through inherited structural systems of violence such as capitalism, racism and sexism.[12] These structural systems of violence enable and produce multiple, intersecting violences through colonial differences, such as gender, race, sexuality, age, etc. Gender as a colonial difference is established through a hierarchy of difference and value and produced through categories of femininity and masculinity.[13] Gender is constituted through other forms of colonial difference such as race, class, etc., so that gender is always racialised and classed, and vice versa. Gender is also constituted through cisnormativity, which is also established through a hierarchy of values that has become legitimised as normal.[14] Cisgender identity and social practices are determined because of the normative gender roles and expectations that are associated with the sex assigned to a person at birth. Transgender identities and social practices refer to a gendered identity that does not correspond to the sex assigned at birth. The cis- and- trans binary produces normative gender which is the gendered paradigm utilised in this research study. Sexuality is integral to gender practices and is established through the hetero- and homo-sexual binary, producing normative sexualities.

Gender as a socio-political system of categorisation determines access or lack of access to power, resources and opportunities.[1,15] Socially valued, heterosexual masculinity, termed hegemonic masculinity, is often associated with aggression and dominance over women, who are expected to submit to men's desires and control.[16] African racialised femininities and African racialised masculinities are positioned as the African 'other' – savage, lazy, dangerous, hypersexual, and only useful in the service of others (labour). Understanding gender as intersectional in South Africa is important in this study because it reveals the multiple, nuanced, historically and socially constructed intersections of violence and norms that situate the demographical data of participants away from harmful and dangerous reductionist, racist, classed and heterosexist colonial categories and understandings.

Forms of GBV include physical, sexual, verbal, emotional, and psychological abuse, threats of such acts or abuse, coercion, and economic or educational deprivation, whether occurring in public or private life, in peacetime, or during armed or other forms of conflict. GBV may cause death, physical, sexual, psychological, emotional or economic harm.[1,17] In some low- and middle-income countries, harmful practices such as female genital cutting/mutilation (FGC/M), child marriage, and bride kidnapping are still widely practiced, despite advances in legislation to ban these violations of girls' and women's rights. FGC/M, for example, is still performed in many countries of East and Southern Africa – Eritrea (89%), Ethiopia (74%), Kenya (21%), Uganda (1%). Child Marriage is prevalent in countries such as Mozambique, Eritrea and Ethiopia. Other practices such as bride kidnapping (*ukuthwala*), which is the traditional practice of abducting young girls for marriage, is still prevalent in the South African context.[18] Cultural practices that have been classified as a violation of girls' and women's rights, such as female genital mutilation (FGM) in Somalia, Ethiopia, and Sudan and labia elongation and virginity testing in Eastern and Southern Africa, are also prevalent. In these contexts, GBV not only causes immediate harm but also has long-term repercussions on the survivors' physical, mental, and socio-economic well-being.[18,19]

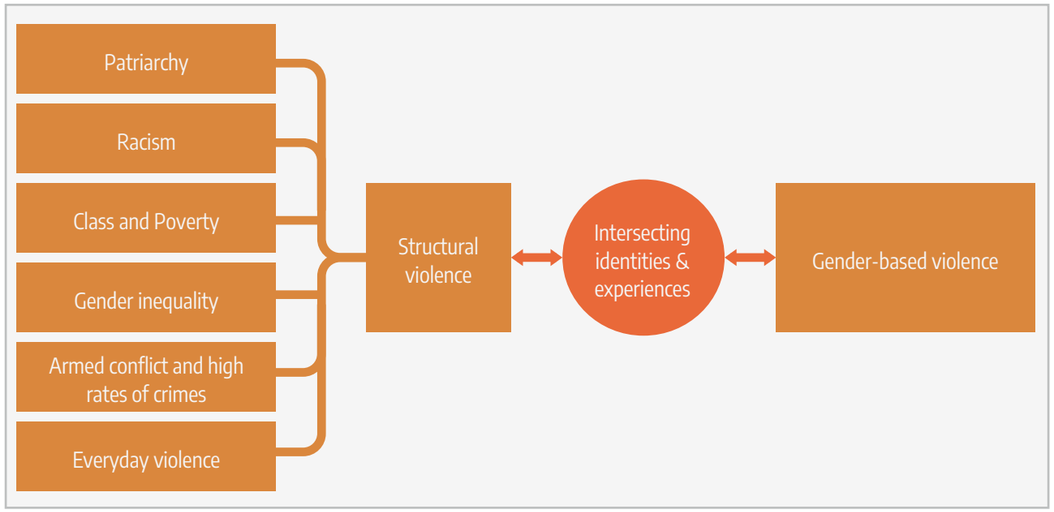
Research from different populations and settings on victimisation has highlighted that GBV is endemic not only in South Africa but also in other countries in sub-Saharan Africa (SSA) and globally.[20] According to the 2020 United Nations report, approximately one third of women across the globe have experienced intimate partner violence (IPV) in the form of either physical or sexual violence, and 18% have experienced such violence in the past 12 months.[19] When accounting for sexual harassment, this figure is even higher. According to the World Health Organization's 2018 prevalence estimates on violence against women, approximately one in three women globally (30%) have experienced physical and/or sexual violence at some point in their lives.[21] The majority of this violence is perpetrated by intimate partners. Specifically, nearly one-third (27%) of women aged 15 to 49 who have been in a relationship report having been subjected to physical and/or sexual violence by their intimate partner.

Studies that have focused on male perpetration of GBV remain limited. A multi-country study by the United Nations (UN) on why some men use violence against women had varied prevalence rates for rape across countries, ranging from 10.0% in Bangladesh to 62.0% in Papua New Guinea. Varied proportions were also observed for ever-partnered men who reported ever having perpetrated physical and/or sexual intimate partner violence, ranging from 30% to 57%.[11,22] A systematic review of GBV victimisation and perpetration in SSA reported prevalence rates of between 13.9% to 97%.[23] These high rates show that SSA faces considerable obstacles in addressing GBV. In this region, GBV is often driven by longstanding cultural norms and socio-economic factors that contribute to the intensification of the problem.

1.2. Conceptual framing of GBV in South Africa

The study is framed using an interdisciplinary approach, drawing on theories of structural violence, intersectionality, critical feminist theory and queer analyses of power. Structural, relational, and individual drivers of GBV are interconnected through multiple, bi-directional pathways. These interactions are complex and mutually reinforcing, such that GBV in turn, also reinforces structural oppressions and inequalities (Diagram 1).

Diagram 1: An intersectional framing of GBV (diagram adapted from Murshid et al., 2020)



In conceptualising and framing GBV, the study also draws from the 2020–2030 South African National Strategic Plan (NSP) on Gender-Based Violence and Femicide (GBVF), which frames GBV as perpetuated by the widespread existence of gender inequality and is deeply entrenched in patriarchal gender norms. These norms create, legitimise, and sustain an environment in which unequal power dynamics between genders (such as a belief that women should be working in the household and that they should obey their husbands) are normalised, fostering conditions that enable and justify violence against women and marginalised genders. This systemic inequality manifests in various forms, including economic disparity and limited access to education. It is also seen in social and cultural practices that devalue and oppress certain genders, thereby reinforcing the cycle of violence.

The NSP on GBVF provides a unified strategic framework aimed at guiding the national response to GBVF, envisioning a South Africa free from GBV against women, children, and LGBTQIA+ individuals. The NSP is structured around six key pillars, namely:

1. accountability, coordination, and leadership
2. prevention and social cohesion
3. justice, safety, and protection
4. response, care, support, and healing
5. economic power
6. research and information management

This national GBV survey directly aligns with the objectives of pillar 6, focusing on conducting research and providing information to enhance the country's understanding of the various forms, scope, and nature of GBVF, both broadly and for specific groups in South Africa.

This study uses the intersectionality framework that shaped the NSP. The conceptualisation of GBV in this study was also guided by Article 1 of the Maputo Protocol, which defines violence against women as all acts perpetrated against women that cause or could cause them physical, sexual, psychological, and economic harm, including the threat to take such acts or to undertake the imposition of arbitrary restrictions on or deprivation of fundamental freedoms in private or public life in peacetime and during situations of armed conflicts or of war.[15]

In line with the intersectionality lens, the study sought to explore how multiple structural systems, social identities, and experiences – such as gender, sexuality, age, race, class, and (dis)ability, amongst others – overlap in mutually reinforcing ways to produce and compound contexts of power, violence, and vulnerability.[24] In the context of South Africa, an intersectionality framework helps to reveal how structural systems of power are interconnected and manifest at the level of interpersonal identities that shape individuals' experiences of violence and the perpetration of violence. It also situates violence in communities within a broader historical and sociological context. This approach recognises that people do not experience or perpetrate GBV in a vacuum, but rather through the complex interplay of historical legacies, space, power, and various social and personal identities.[25] Employing an intersectionality framework in GBV research in South Africa should enable the identification and addressing of multiple layers of victimisation and perpetration. By acknowledging the diversity of experiences among GBV victims/survivors and perpetrators, policymakers, researchers, and activists can develop more targeted and effective strategies to curb GBV.

1.3. GBV in South Africa

South Africa is a society profoundly marked by violence and continues to grapple with the enduring effects of decades of institutionalised racism, sexism, exclusion, structural violence, and other factors that have persistently undermined human development and positive social cohesion.[1] The President of South Africa acknowledged that GBV was a severe socio-economic problem, which is fundamentally rooted in unequal power dynamics between women and men.[4] Violence against women has been acknowledged as a 'national crisis' and a 'second pandemic' that is increasingly recognised not just as a national issue but also as a serious human rights abuse and an increasingly important psychosocial and public health concern that affects all sectors of society.[5-8] GBV in the country transcends cultural, socio-economic, ethnic, and other socio-demographic divides.[6, 7] The persistence of GBV reflects deeply ingrained societal norms and structures that perpetuate male dominance and reinforce gender hierarchies and power imbalances within families and communities, leading to female subordination, systemic inequalities, and violence against women.[9]

South Africa contends with some of the globe's highest homicide rates and some suggest has one of the highest rates of GBV, encompassing intimate femicide, rape, and IPV.[2,3] Data from an SAMRC study highlight the severe issue of GBVF in South Africa. In 2017 alone, an alarming 2,407 women aged 14 and older were murdered, with an average of three women per day killed by their intimate partners.[26] The rate at which women are killed by intimate partners in South Africa is five times higher than the global average.[27]

Globally, six women are killed every hour by men, most by men in their own family or their partners, while in South Africa, a woman is killed every four hours.[3,27] These statistics illustrate the widespread and ongoing nature of GBV, with most perpetrators being men known to the victims, including intimate partners and family members. Between October and December 2023, over 15 000 sexual offences, with rape accounting for 80.0%, and more than 14 000 assaults against women were reported in the country.[28] The recently released Governance, Public Safety, and Justice Survey reported an increase of 3.6% from the previous reporting period in 2022–2023. Sexual offences in the past five years have increased from 112 000 in 2022–2023 to 116 000 000 in 2023–2024. Sexual offence in the past 12 months increased from 30 000 in 2022–2023 to 52 000 2023–2024.[28] The Institute for Security Studies (ISS) reported that in 2022/2023 there were a total of 42 780 reported rape incidents. The different figures for rape highlighting the ongoing challenges of gathering these statistics in South Africa.[29] The economic impact of GBV is equally significant. Based on the prevalence rate of between 20.0% and 30.0%, it is estimated that GBV costs to the South African economy could range between R28.4 and R42.4 billion annually, amounting to between 0.9% to 1.3% of the country's gross domestic product (GDP).[30]

Accurately determining the prevalence and incidence of GBV in all its forms is challenging due to pervasive under-reporting and inadequate documentation of cases. Contributing factors include the lack of an integrated national surveillance system, stigma, fear of retaliation, and a lack of trust in authorities tasked to respond to GBV.[10] Despite these challenges, there has been a concerted effort over the past decade by grassroots and international civil society organisations, international experts, researchers, academics, and governments, which has led to a significant transformation in public awareness of GBV. This activism has further led to advocacy for the measurement of GBV using representative population-based samples and internationally recognised methodologies.

To date, the country has depended on police data and statistics that have been derived mostly from provincial GBV surveys, GBV studies within selected populations, and data from other national surveys that were not specifically designed for GBV, such as the South African Demographic and Health Survey (SADHS) and the South African National HIV Prevalence, Incidence, Behaviour, and Communication Survey (SABSSM). Peltzer et al., for example, used the 2012 SABSSM survey to estimate the prevalence and influence of socio-demographic and health characteristics on IPV victimisation and perpetration among women and men 15 years and older in the preceding 12 months.[31] They found that 8.5% of women had experienced any form of IPV in the preceding 12 months, and 3.5% of the women had perpetrated IPV in the preceding 12 months. Among men, 5.0% had experienced any form of IPV in the past 12 months, and 4.4% had perpetrated IPV in the past 12 months.[31] Another study that used the 2017 SABSSM survey data found that 13.1% of adolescent girls and young women (AGYW) in South Africa indicated that they had experienced IPV.[32] Other studies in the past ten years highlighted the prevalence and impact of GBV across different demographics in South Africa. The SADHS 2016 provides data on health and demographic characteristics, including a module on IPV and physical and sexual violence committed by non-partners. An earlier GBV population-based study in the province of Gauteng (2011) revealed that 37.7% of women experienced physical and/or sexual IPV, 18.8% reported experiencing sexual IPV, and 46.2% reported economic or emotional abuse.[33] In 2016, randomised controlled trials in eThekwini focused on both women and men, examining the dynamics of violence and evaluating interventions aimed at reducing it. Similarly, a study in Diepsloot township investigated men's involvement in GBV and assessed the effectiveness of behavioural interventions.[1] Challenges with non-population-based studies are that they cannot be generalised to the South African population, and they consistently tend to report much higher prevalence rates, with some exceeding 50.0%.[1]

Research on the perpetration or use of violence by men remains limited in South Africa. However, studies on the perpetration of violence also consistently indicate higher levels of violence among men. In one study, Jewkes et al. found that rape perpetration was highly prevalent in South Africa, with 20.0% of young South African men enrolled in their study reporting that they had either raped or attempted to rape over the two years of follow-up, with a total rape incidence of 11.2 per 100 person-years.[34] These results are consistent with other South African studies.[35]

1.4. GBV and associated factors

GBV in South Africa is associated with multifaceted and interlinked factors operating at individual, familial, and societal levels, including historical and cultural contexts, structural conditions, psychological influences, substance abuse, and systemic issues. Understanding the factors associated with GBV in the country is essential for prevention and intervention strategies.[17,36] For example, the 'What Works Programme' aims to identify and promote successful interventions to reduce violence against women and girls through rigorous research. By examining socio-cultural norms that influence attitudes toward violence, the programme develops tailored interventions to change harmful behaviours and norms, contributing to more effective GBV strategies in South Africa.[37]

The history of systemic violence, racism and oppression has fostered a culture in which GBV is more likely to occur. Besides ushering in racial inequality into South Africa, colonialism also promoted and cemented binary and unequal gender relationships between men and women. While apartheid is frequently regarded as the main context for understanding current violence in South Africa, it is crucial to also consider the deeper impact of settler colonialism and slavery. This broader historical perspective provides essential insights into the ongoing legacies of violence affecting contemporary gender issues.[12] The apartheid regime's use of violence as a tool for control left a legacy of normalised violence, including GBV.[36] Men, especially those in marginalised communities, were often brutalised by the state, became desensitised to violence, and perpetuated it in personal relationships, asserting control over women to cope with their powerlessness.

In the current context, globally, hegemonic masculinity is still reflected in the expectations that men should be breadwinners. These beliefs are strong and pervasive.[38] Men often pin their identities on this financial provider role but, in the current economic circumstances, this is impossible due to high levels of poverty, unemployment, and economic instability.[39] These conditions often exacerbate stress and frustration among men, which can manifest as violence against women and children. The rapid social and economic changes and the struggle to redefine male identities in the democratic context have also contributed to the male perpetration of GBV in South Africa.[40] Conversely, historical economic injustices that have perpetuated enduring poverty among women and their families significantly contribute to GBV. Poverty and GBV are mutually reinforcing, with poverty elevating women's risk of experiencing violence, and GBV increasing the likelihood of poverty.[41] Poverty fosters economic dependency on abusive partners, while economic stress may heighten the likelihood of conflicts over resource priorities.[16] Additionally, poverty, coupled with low education and unemployment, exacerbates women's vulnerability to IPV.

Also, conventional gender norms and the socialisation of boys and young men in South Africa often reinforce aggressive and dominant behaviour, often associated with GBV.[42] From a young age, boys are taught to suppress emotions and avoid behaviours perceived as weak or feminine. This type of socialisation can result in the normalisation of violence as a means of expressing masculinity. Media and popular culture also play a role in shaping notions of dominating (hyper) masculinities. Violent male figures are often glorified in movies, music, and sports, reinforcing the idea that strength and dominance are inherently tied to male identity.[43] This social reinforcement can make it difficult for men to reject violent behaviour and adopt more equitable and respectful attitudes toward women.[42]

However, cultural and religious narratives often reinforce gender hierarchies by depicting men as dominant and women as subordinate.[44] Patriarchal values are significant contributors, fostering environments in which male dominance, assertiveness, and entitlement are accepted while women are expected to be submissive and nurturing.[45] These patriarchal values shape attitudes and behaviours that perpetuate violence against women and children as a means of maintaining male dominance and control.[46] In many rural areas and traditional communities, these patriarchal values are even more pronounced. Practices such as *ukuthwala*, exemplify the cultural acceptance of GBV.[47] While *ukuthwala* is illegal, its persistence underscores the challenge of changing deeply rooted cultural practices. Conversely, in gender-equitable settings, there is a normative expectation to protect women from GBV, leading to more active community intervention. Sanctions against husbands who beat their wives can help control IPV levels.

Religious beliefs can either perpetuate or challenge GBV. Some interpretations of Christianity, Islam, and traditional African religions reinforce male headship and female submission, leading to the acceptance of GBV as a disciplinary measure.[48] Conversely, many religious leaders are increasingly advocating for gender equality and non-violence. Efforts to reinterpret religious texts and cultural practices in ways that promote respect and equality are essential for changing attitudes and behaviours related to GBV.

Globally, data shows strong correlations between having experienced or witnessed any form of violence as a child (childhood trauma) and adult perpetration of violence.[39] Childhood sexual abuse for example has been linked to increased mental distress in adulthood, particularly in terms of anxiety and depression.[53] Exposure to violence, whether as a victim or a witness, can therefore have severe psychological impacts including post-traumatic stress disorder (PTSD), depression, and anxiety, which in turn can increase the likelihood of violent behaviour as a maladaptive coping mechanism.[49] Evidence also highlights the complex relationship between substance abuse and GBV.[22,50,51] Substance abuse is both a catalyst and a consequence of GBV. Alcohol and drug abuse can impair judgment, reduce inhibitions, and increase aggression, leading to violent behaviour. Conversely, victims of GBV may turn to substances as a coping mechanism for the stress and trauma associated with living in a violent environment.

Additionally, there is a documented association between GBV, psychological distress, and socio-behavioural risk factors, including unprotected sex, having multiple concurrent partners, and engaging in transactional or coercive sexual relationships. Such behaviours not only increase the risk of sexually transmitted infections (STIs) but also exacerbate the transmission of HIV.[52, 53]

The intersection of GBV perpetration and socio-behavioural risk factors creates a cycle of violence and poor sexual health outcomes, further exacerbating the health risks faced by both perpetrators and their partners. At the community and societal levels, factors such as social norms that condone or perpetuate gender inequality, harmful masculinities, and limited access to resources and support services can contribute to the perpetuation of GBV. These factors create an environment in which violence against women and other marginalised groups is normalised or tolerated, making it more difficult to challenge and address GBV effectively.[54,55]

1.5. Existing legislation on GBV in South Africa

South Africa has implemented a robust legislative framework to respond to and curb GBV. Existing legislation includes the Domestic Violence Act 116 of 1998,[56] the Sexual Offences and Related Matters Act 32 of 2007,[57] and the Prevention and Combating of Trafficking in Human Persons Act 7 of 2013.[58] Recent amendments have sought to strengthen these laws further, including the Criminal Law (Sexual Offences and Related Matters) Amendment Act 13 of 2021,[59] the Criminal and Related Matters Amendment Act 12 of 2021,[60] and the Domestic Violence Amendment Act 14 of 2021.[61] These legislative frameworks aim to enforce stricter bail conditions for perpetrators and tackle other social justice issues, including historical violence, socio-economic disparities, and entrenched gender norms, through comprehensive strategies focused on prevention, protection, and support for survivors. [62-64,65]

However, laws and interventions alone are often insufficient as shown by the high rates of GBV found in studies included in this report. Reported cases of GBV represent a drop in the ocean as many more cases remain unreported and undocumented. Despite significant legislative and policy efforts, the prevalence of GBV, particularly male-perpetrated violence against women, persists at alarming rates. The effectiveness of law enforcement and the judicial system plays a crucial role in either curbing or perpetuating violence. While South Africa has legal frameworks aimed at combating GBV, implementation and enforcement remain

challenging. Factors such as police complacency, corruption, lack of training, and inadequate resources result in poor responses to GBV cases.[64] Survivors often face barriers when reporting incidents, such as victim-blaming, colluding with the perpetrators, lack of protection, and a judicial system that often fails them due to lengthy legal processes, lack of legal representation, and re-traumatisation during court proceedings.[66] Furthermore, lenient sentencing and low conviction rates for GBV perpetrators undermine the seriousness of the crime and fail to deter future violence.[67]

1.6. Rationale for the National GBV Survey

South Africa, along with other countries in the region and globally, is expected to report to the United Nations on progress towards achieving Sustainable Development Goal (SDG) 5, which aims to achieve gender equality and empower all women and girls. This includes targets to 1) end all forms of discrimination against women and girls everywhere and 2) eliminate all forms of violence against women and girls in public and private spheres, including trafficking and various types of exploitation. These goals set benchmarks for stakeholders in every country to enhance efforts and work towards reducing the prevalence of GBV. This requires a comprehensive understanding of GBV prevalence to inform effective policy responses.

However, research on GBV in South Africa and globally faces significant challenges due to the heterogeneity of research designs and methodologies, which impedes the ability to make cross-contextual comparisons and generalisations. South Africa lacks a national estimate on GBV and its drivers, relying on disparate sources like police statistics, SADHS, and various other national and sub-national surveys using differing methodologies. Consequently, there are conflicting estimates on rates of GBV, including IPV and non-partner sexual violence. To further advance the effectiveness of responses to GBV in South Africa, the Human Sciences Research Council (HSRC) and its collaborators have undertaken a detailed data collection effort aimed at assessing the extent, nature, prevalence, and impact (consequences) of GBV across the country.

This baseline study provides crucial evidence-based data that will inform policies and interventions outlined in the NSP (2020), responding to GBVF. This national GBV survey directly aligns with the Research and Information Management objectives (Pillar 6 of the NSP), focusing on conducting research and providing information to enhance the country's understanding of the various forms, scope, and nature of GBVF, both broadly and for specific groups in South Africa. Such evidence is critical for designing interventions that not only respond to violence but also prevent it by addressing its root causes. Ultimately, this study aims to strengthen the prevention of GBV and enhance the overall efficacy of efforts to eradicate this pervasive issue by providing data that can be used to understand the factors that drive GBV within the South African context.

1.7. Aims and objectives

1. To describe the prevalence and patterns of experiences of physical, sexual, emotional and economic GBV among women from all provinces in South Africa

2. To describe the prevalence and patterns of perpetration of physical, sexual, emotional and economic GBV among men from all provinces in South Africa

3. To determine factors associated with GBV victimisation and perpetration, including:

- **3.1.** Gender, sexual norms and attitudes
- **3.2.** Socio-behavioural risk factors including alcohol and substance use, condom use, number of sexual partners and transactional sex
- **3.3.** Mental health, including depression among victims and perpetrators

4. To measure responses to experiences of GBV and the health and economic impacts of GBV among those who are victimised

5. To determine the extent of experiences and perpetration of GBV attributed to the COVID-19 pandemic and the lockdown period

CHAPTER 2

METHODOLOGY

2.1. Study design

The study used a population-based, household survey approach, applying a multi-stage stratified cluster survey design.

2.2. Study population

The GBV study included individuals aged 18 years and older, living in households in all nine provinces of South Africa. Due to ethical complexities and risks in obtaining consent from persons younger than 18 years in household settings, only persons aged 18 years and older were invited to participate. While many WHO multi-country studies still sample women aged 15 to 49 only, this study included men and women aged 18 and older.

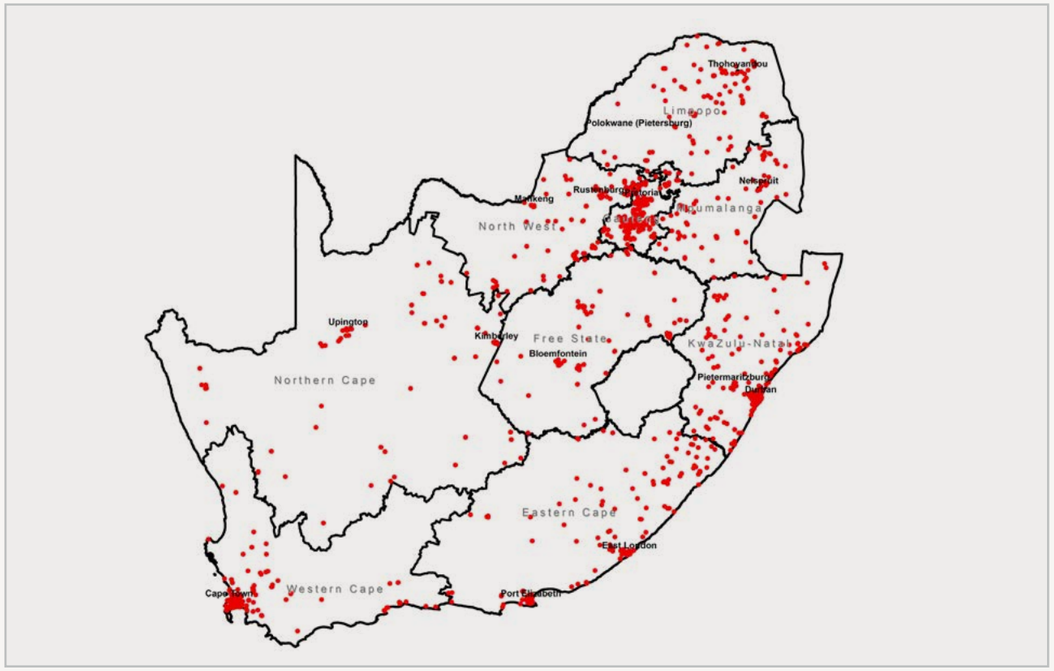
The inclusion criteria for participation were: individuals aged 18 and older living in the selected households who were able and willing to provide verbal informed consent. For this study a household member was defined as any person who:

- usually lives in the household,
- is visiting and has been sleeping there for at least four weeks,
- is working as a domestic helper in the household and usually sleeps there for at least five nights a week).

The exclusion criteria were:

- people who were unwilling to participate in the survey,
- people who were unable to give verbal consent due to cognitive impairment or intellectual disability,
- people staying in educational institutions, old-age homes, hospitals, hostels, uniformed-service barracks or prisons.

Figure 3: Distribution of selected small area layers (SALs)



2.3. Sampling

A multi-stage stratified cluster random sample design was implemented in this survey wherein:

- small area layers (SALs) were sampled probability proportional to size
- households within SALs were sampled using a systematic random sampling approach
- one individual was selected within the households – if there was more than one person aged ≥18 years, a Kish grid was used to randomly select a person to be invited for an interview within a household

South Africa is divided into 84 907 geographical areas called small area layers (SALs) as defined and mapped by Statistics South Africa. SALs have clear boundaries, with approximately 200 to 300 visiting points (VPs) per SAL. The SAL was used as the primary sampling unit (PSU). SALs were stratified by province and locality type, classified as urban, rural informal (tribal areas), and rural formal (commercial farms). The allocation of SALs was disproportionate with intentional over-sampling of areas dominated by Indian, coloured or white race groups and over-sampling of SALs in the Northern Cape, which is sparsely populated, to ensure the minimum required sample sizes for the three minority race groups in South Africa and the Northern Cape province (Figure 3).

The total number of SALs required to reach the targeted sample size was determined as described in the sample size estimation section (2.4). At the first stage of sampling, 1 096 SALs were sampled with a probability proportional to size (PPS) with the number of VPs within each SAL used as a measure of size. The selected SALs were randomly sampled in the same way but equally categorised as women (n=548) and men SALs (548). A VP, in the simplest sense, refers to a household. The PPS sampling ensures that SALs that have a large number of VPs have a higher chance of being selected. During the study, entry into 46 SALs was not possible due to violence and stakeholder refusals in those areas. These SALs were then replaced with neighbouring SALs that had a similar demographic profile.

VPs and households within sampled SALs were the secondary sampling units (SSUs). In each of the sampled SALs, a list of geocoded VPs was developed by the geographic information systems (GIS) unit at the HSRC. The list provided the specific location of the geographic boundaries, with the locations of the VPs shown on maps. A total of 20 VPs were sampled within each selected SAL using systematic random sampling.

The systematic random sample followed a serpentine process to ensure that all VPs within a SAL had an equal chance of being selected. This sampling scheme is also most suited in studies that conduct highly sensitive research, such as GBV. This is important, especially in closed communities in which most people know each other, because it leaves a suitable spacing between each sampled household. In cases in which some VPs had more than one household, a Kish grid was used to randomly select one household from the multiple households.[68]

The selected individual was the ultimate sampling unit (USU). In the 548 SALs selected to complete the women's instrument, all the household members who identified as women and were ≥18 years were listed. The Kish grid was used to randomly select a woman from the household listing to participate in the study if there was more than one woman aged ≥18 years. The same approach was followed in the other 548 SALs that were designated for the completion of the men's instrument. Only one participant was interviewed per household. Box 4 describes the sampling steps that were followed.

Box 4: Steps in sampling for national estimates

Define:

1. Target population – people aged 18 years and older in South Africa living in households.

2. Sampling frame – the national SAL dwelling frame of Statistics South Africa of approximately 84 907 SALs.

3. Primary sampling units (PSU) – 1 096 SALs from the sampling frame.

4. Measure of size – the estimated number of VPs that were used in sampling SALs.

5. Allocate the sample – disproportionate allocation of SALs according to the province, geographic type (locality type) and race groups.

6. Strata – provinces* (n=9) and locality types** (n=3).

7. Reporting domains – provinces (n=9), locality type (n=3), race (n=4) and sex.

8. Secondary sampling units (SSU) – 20 occupied VPs systematically sampled from each of the selected 1 096 SALs. The VP selection was based on the HSRC GIS-generated list of VPs within the sampled SAL.

9. Ultimate sampling unit (USU) – one individual per sampled household.

*Provinces: Western Cape, Northern Cape, Eastern Cape, KwaZulu-Natal, Free State, Mpumalanga, Gauteng, Limpopo and North West; **Locality type - Urban areas, Rural informal areas (tribal) and Rural formal area

Table 1: Targeted sample size allocation for estimating baseline prevalence of GBV in the general population

Province	% Population	Sample size proportionate to size	Number of SALs needed if 20 HH per SALs are selected	Number of SALs per locality type
Gauteng	29%	5 794	329	110
KwaZulu-Natal	18%	3 614	212	71
Western Cape	12%	2 407	143	48
Eastern Cape	9%	1 867	100	33
Limpopo	9%	1 707	88	29
Mpumalanga	9%	1 619	83	28
North West	7%	1 328	71	24
Free State	5%	928	48	16
Northern Cape	2%	407	21	7
Total	**100%**	**19 671**	**1 096**	**365**

HH-Households

2.4. Sample size estimation

The sample size calculations were informed by the 2016 Demographic and Health Survey national estimates of violence experienced by partnered women in South Africa.[69] These estimates were deemed plausible as they are based on a representative household survey that is not affected by the reporting bias that occurs in crime statistics. The SADHS 2016 report, estimated that the prevalence of lifetime physical violence among partnered women was 21%. This was used to calculate the sample. A total sample size of 19 671 was calculated in order to detect a 10% reduction in the overall prevalence of physical violence against women with 80% power at 5% level of significance, assuming a 70% response rate and a design effect of 2. Sample size allocation for each province was proportional to the population size (Table 1) as per the 2020 mid-year population estimates.[70]

In an attempt to increase the participation of socially excluded and marginalised groups, such as LGBTQIA+ persons and people with disabilities, the study design was adapted to include respondent-driven sampling (RDS) to supplement the household sampling approach after consulting experts in GBV survey methodology. Using this chain-referral sampling method, we attempted to access the social networks of eligible participants from these hard-to-reach population groups found in the households.

This sampling method did not yield the expected results, and a decision was taken to exclude participants sampled via the RDS approach from the analysis and results presented in this report. This report therefore focuses on participants in the original household sample only. However, members of LGBTQIA+ community and people with disabilities who were found in households without the use of RDS were automatically included in the survey. A total of 153 people were sampled via RDS, of which 71 identified as being from the LGBTQIA+ community and 81 reported that they were persons with a disability. The RDS component of the survey therefore did not contribute to improving the precision of survey estimates for the overall outcomes nationally. A separate paper is being prepared to present findings from the RDS component and highlight the challenges and lessons learned for future research.

2.5. Questionnaire development and measures

Since 2000, over 70 countries have conducted GBV surveys, at least 40 of which were at a national level.[19] Where these surveys have been conducted, the scope has differed depending on the needs and available resources in each country. In some countries, GBV was studied from a victim perspective using only the WHO women's questionnaire. The South African National Gender-Based Violence Study, however, included GBV perpetration as well, and therefore used both the WHO questionnaire, which was completed by women, and a separate survey tool – the United Nations men's questionnaire – that was completed by men.

The women's questionnaire collected data on demographic characteristics, various forms of IPV, non-partner violence, gender attitudes, power relations, childhood experiences of violence, injuries, and help-seeking behaviours. The men's questionnaire collected data on demographics characteristics, perpetration of various forms of IPV, gender attitudes, childhood experiences of violence, and men's knowledge about laws and policies. To collect data that has the potential for comparison across the continent and the world, the WHO Multi-Country Study on Women's Health and Life Experiences questionnaire and the United Nations Multi-Country Study on Men and Violence questionnaire were used.[11] The WHO Women's Health and Life Experiences Questionnaire version 12.06 and the Core Men's Questionnaire version 3.0 were adapted to ensure cultural sensitivity, utilisation of common local terms where possible, and relevance to the South African context. Moreover, questions from the Citizen Survey conducted by UN Women were adapted and included in both questionnaires to comprehend the experiences of victimisation and perpetration of GBV during COVID-19 lockdowns.[71] A

multidisciplinary team of 10 international and local experts in GBV, epidemiology, public health, biostatistics, and individuals with expertise in questionnaire development, was assembled. The questionnaires were revised and tested over three workshops. Subsequently, the instruments were translated by individuals fluent in English into eleven official South African languages. HSRC researchers and field supervisors proficient in the local languages reviewed the translations to ensure that they accurately conveyed the meaning of the English versions and captured culturally specific terms and concepts. Details of the measures used are provided in Appendix A. The questionnaires included 12 modules designed to obtain the information listed in Box 5.

The survey instruments were tested in a pilot study that took place between the 8th and 11th of September 2021 in Gauteng. Ten pilot SALs were selected and 20 visiting points per SAL were randomly selected. A target of 250 respondents (inclusive of RDS) was set. Six female teams and three male teams conducted the pilot data collection. From the 10 SALs selected, only nine were visited; one could not be accessed as it was situated in an unsafe neighbourhood and required police to escort the team, which was unavailable at the time of community entry. Interviews were conducted in the participants' language of choice. The overall response rate was 46.0% (n=189). The response achieved was satisfactory for the women and poor for the men. Out of 120 women that were approached 46.0% (n=87) agreed to be interviewed. While out of a total of 70 men that were approached 38.6% (n=27) agreed to be interviewed. This data was used to come up with strategies to improve the uptake of the survey, especially among men. During the pilot, an assessment was also made on the uptake and the ease of completing a self-administered section in the men's questionnaire. The pilot provided insights into questions that were ambiguous, easily misunderstood, or problematic. Final modifications to the questionnaires were made based on the pilot results and feedback from data collectors and supervisors after a debriefing workshop.

Box 5: Structure and modules of the survey tool

Adapted WHO questionnaire – Victimisation	Adapted UN questionnaire - Perpetration
Administration form	Administration form
Household selection form	Household selection form
Household questionnaire	Household questionnaire
Characteristics of the respondent and their community	Socio-demographic characteristics and employment
General health status	Childhood experiences
Reproductive health	Attitudes about relations between men and women
Information regarding children	Intimate relationships
Characteristics of current or most recent partner	Health and wellbeing
Attitudes toward gender roles	Policies
Experiences of partner violence	Self-administered questions on violence perpetration
Injuries due to violence	COVID 19 Lockdown-related violence
Impact and coping mechanisms used by women who experience violence	Respondent feedback on questionnaire
Non-partner violence and COVID 19 lockdown-related violence	
Economic autonomy (incorporated in section 1 of the adapted WHO questionnaire)	
Respondent feedback on questionnaire	

2.5.1. The duration of data collection

Field data collection started in February 2022. The average duration of data collection in a SAL was between five and seven days. Due to COVID-19-related restrictions, data collection and refresher training had to be implemented in a phased approach. The full complement of teams only started in March 2022. Due to budgetary constraints, the survey was halted in December 2022, with data collection being incomplete. At that point 92.4% of SALs had been completed. However, critical SALs were still outstanding. These included White SALs in the Western Cape, SALs that could not be accessed in the first round due to crime or safety concerns (and had to be replaced), farms in the Western Cape and Eastern Cape, and Indian SALs in Gauteng. The survey was resumed in November 2023 to mop-up the outstanding SALs. This was completed in February 2024. Data collection was confined to only four provinces and only 70 SALs were targeted for visits by the teams. Data collection was successfully completed in 52 SALs. Quality assurance of fieldwork was implemented between September and December 2022.

2.6. Fieldwork procedures

2.6.1. Recruitment and Training of field teams

Field staff were recruited in 2021 with preference being given to candidates with previous experience in collecting survey data in the health and related fields, experience with gender and GBV work, a qualification in social sciences such as psychology, sociology, counselling, or development and gender-studies. To achieve inclusivity, we used our existing database and research networks to recruit persons with disabilities and those who identified as LGBTQIA+. Field teams were matched by sex (women collected data in women's SALs and men in men's SALs), gender, language, and ethnicity to the demographics of the SALs selected in each province.

Training workshops were conducted over a period of two weeks. The first week focused on introducing the study and covered mostly the theoretical aspects of the study, including: objectives of the study, sex and gender, gender sensitization, masculinities, gender norms and roles, gender-based violence, study methodology, ethics in research, safety measures in field research, quality control, COVID-19 Standard Operation Procedures (SOPs), roles and expectations of field staff, admin processes, working and employment conditions. In week two the focus shifted to the practical implementation of the study in the field. Training sessions focused on introducing the questionnaires, and how to complete computer-assisted personal interviews (CAPI) using portable tablets, and administration of the consent form and the questionnaire. All trainees were required to participate in role plays in which different scenarios were enacted to test their competence. Mental health SOPs for staff and participants were also introduced, coupled with practical ways of handling difficulties in the field. Trainees who did not meet the required pre-set standard in the purpose-specific competency tests were not contracted to implement fieldwork.

All staff members were issued with fixed-term contracts due to the nature of the work and the need to reduce any pressure that could lead to coercion of participants if field staff were compensated per questionnaire. Field staff members were contracted using projections for data collection in each province. Contracts were extended on a needs basis. For example, selected staff members were offered extension of contracts to complete the work in provinces where data collection was not completed as projected.

2.6.2. Community entry

Community entry was done before the team visited the SALs. It was aimed at establishing relationships with stakeholders like community policing forums, ward councillors, and neighbourhood watch committees. In rural areas stakeholders included traditional leaders and farmers' unions.

To minimise potential harm and any related stigmatisation, the study was titled **"The South African National Survey on Health, Life Experiences, and Family Relations"**. Using a safe or neutral title is recommended by the WHO. No references to violence were made on any publicly available communication or promotional material. Only the consent form that was administered to one individual per household mentioned the nature and sensitivity of the survey.

2.6.3. Data collection

Survey teams were distributed, proportionally to size, throughout the nine provinces. Two project directors and two project managers oversaw the teams and the day-to-day implementation of the study. Additionally, six provincial coordinators offered support to the field teams. Each team consisted of an average of four data collectors led by a supervisor.

Data collection teams used maps and global positioning system (GPS) coordinates to navigate to SALs and households. The survey VPs were identified and verified by the supervisor. Those VPs identified on-site to be non-residential structures were recorded as invalid. Invalid VPs were not replaced. Where no one was home at the time of the data collection visit, up to three attempts were made to visit the household.

At selected VPs, data collection staff approached the head of the household to introduce themselves, explain the generic purpose of the survey, and provide information to the head of household. If the household head consented for their household to participate, a data collector administered a brief questionnaire to collect data on the household characteristics and household members. Thereafter they completed a household listing, which listed all the women or men (dependent on whether or not they were in a SAL allocated to women or men) in the household, their ages, and whether or not they were residents of the household. One woman or man was then randomly selected to participate from the list of all women or men in each household. If there was more than one participant aged 18 or older, the Kish grid was used to select one participant per household.

2.6.4. Questionnaire administration

Questionnaires were administered by a trained interviewer. Interviews were conducted using computer-assisted personal interviews (CAPI) on a tablet. Households were visited up to three times, to ensure that one interview was conducted with a randomly selected individual in the household. If household members or the selected participant were not home, the data collector visited the household at different times of the day or over weekends to secure an interview. The process for completing an interview was as follows:

- **Household access:** Upon gaining access to the household, the data collector completed the administration form, the household selection form, and the household questionnaire. This initial paperwork was completed by the head of the household to gather basic information about the household and its occupants.
- **Participant selection:** One individual aged 18 years or older from the household was randomly selected to participate in the survey.
- **Privacy and safety:** The data collector explained the importance of privacy and confidentiality to the selected participant. They ensured that a private and secure space was found within the household where the interview could be conducted without interruptions or eavesdropping. If an interview was interrupted or if privacy was compromised, the data collectors were trained to change the subject to maintain the privacy and safety of the participant or reschedule the interview.
- **Informed consent:** Data collectors were trained to read the whole electronic informed consent, and not summarise or alter it in the process. The consent form provided information on the purpose of the study, the nature of the questions, and the rights of participants. Verbal consent was obtained and recorded electronically before proceeding with the interview.
- **Questionnaire administration:** The questionnaires were interviewer-administered. Trained data collectors used introductory scripts at the beginning of each section to ease participants into the questionnaire and provide context for the questions. This approach was designed to ensure comfort and clarity for the participant. All responses were entered directly into the tablet by the data collector, ensuring real-time data capture and reducing the risk of data entry errors. The decision to use fieldworker-enumerators instead of self-administration was informed by data that has shown that self-administration of GBV surveys tends to underestimate prevalence.[72,73] Previous experience conducting similar surveys at the HSRC has also shown that self-administered questionnaires tend to have a high percentage of incomplete sections and often take longer to administer due to participants not being familiar with the questionnaire. This mode of data collection is generally not suitable for participants who are not familiar with the use of a tablet or who cannot read.
- **Confidentiality and bias reduction:** Given the sensitive nature of some sections of the men's questionnaire, a portion of the questionnaire was self-administered as it was specifically designed to enhance confidentiality and minimise social desirability bias. This section allowed participants to provide honest responses to sensitive issues of perpetrating violence without the direct influence of the interviewer. Allowing participants to complete this section on their own encouraged more truthful reporting, thereby improving reporting and disclosure.
- **Compensation/reimbursement system:** This was introduced to facilitate RDS. This recruitment approach is based on the premise that an individual selected at the household (the seed) would be asked to recruit other individuals like themself. However, for this recruitment method to work, we had to introduce a reimbursement system to compensate participants for their time and willingness to invite others to participate. For this purpose, we requested approval to introduce a compensation/reimbursement system from the HSRC Ethics Committee. The approved system entailed offering a store voucher to the value of R50 to all participants in the study, irrespective of whether they were part of the RDS sample or not. Participants in the RDS arm of the study were offered an additional R30 cellphone voucher for every successful recruitment. Offering a R50 store voucher to all participants was done to ensure that there was no perceived prejudice to one group. It was also meant to curb any rumours from spreading about one group receiving a reimbursement and another not receiving anything after participating in the study. Compensation/reimbursement was retained for the duration of the study.
- **Interview completion:** After the interview, the data collector reviewed the responses for completeness and accuracy, addressing any inconsistencies or missing information.
- **Quality assurance:** Supervisors had restricted access to online data on RedCap.[74,75] They were able to verify data uploads and check that questionnaires were completed. They could not amend questionnaires, instead they were expected to notify a data manager about any discrepancies identified. Quality assurance checks were conducted daily, with supervisors having full access to data managers and IT personnel managing the RedCap system.

2.6.5. Support for staff members during fieldwork

The field teams were carefully managed to prioritise their safety and that of participants. Due to the risk of vicarious trauma and distress, providing on-going support throughout the study was essential. Because of the nature of the work, each field team member was only allowed to interview three individuals per day. Support consisted of debriefings, monitoring/oversight, supervision, and regular performance feedback meetings. From the start of the study, a 'vicarious trauma SOP was included in every staff member's field manual. Staff members were also supported through frequent discussions about the challenges and dilemmas that emerged during data collection. Regular debriefing meetings were held with staff members. These sessions were aimed at sharing experiences and were used to identify staff members who may need additional support or care. All members of staff working on the project were encouraged to utilise the services of the HSRC's Employee Assistance Programme (EAP) that is operated by an independent service provider using a toll-free number that was printed at the back of their project identity cards. The programme is designed to enhance productivity and job performance by addressing psychosocial, legal, financial, and work-related problems.

2.6.6. Care and support for participants during fieldwork

Maintaining safety for human participants is an important part of all research. There is a higher standard to assure the safety of people at risk of emotional distress and suicide because they are known to be particularly vulnerable. During recruitment, an attempt was made to recruit and appoint staff who had a background or experience in GBV work, psychology, or counselling. SOPs for dealing with emotional distress and suicidal ideation were developed together with referral slips. During the training, the supervisors and the data collectors were trained on how to deal with both. The SOPs also included a step-by-step guide to assessing risk, escalating cases to the provincial coordinator, and referring cases to a professional in the area. Details of local and national NGOs that could be contacted in case of an emergency were also provided to the field teams. As part of community entry, teams were required to locate local service providers that could be used for referrals or additional support.

2.7. Data management, weighting and analysis

2.7.1. Data management

The REDCap mobile application was used to upload electronic questionnaires onto tablets. The records were uploaded on to two separate databases (one for the women's survey and another for the men's survey). The asynchronous transfer occurred via General Packet Radio Service (GPRS), Wi-Fi, 3G or USB cable to any XForms-compatible server. The datasets were retrieved from REDCap and backed up on a MySQL server daily using PHP cron. The data management team ran and merged all submitted forms for each dataset on the MySQL server.

Data cleaning was minimal because questionnaires were programmed with navigation logic as well as entry constraints. Daily uploading of the data allowed for real-time validation and monitoring of fieldwork progress. A queries report was developed on REDCap, and the data monitors auto generated the list of queries and shared it with the field team to provide any missing information. This process also allowed for the daily updating of statistics on Power BI dashboards. A geo-location and time for survey completion were automatically stamped onto each questionnaire thereby improving quality control.

Data collectors did not have access to the data uploaded on the server. The data stored on the server was only accessible to the project's data manager and the questionnaire developers with restricted rights. The processed, cleaned, and verified datasets were sent to the data analysts.

2.7.2. Weighting and benchmarking of the data

Weighting procedures were performed before data analysis. The list of selected SALs included the selection probabilities per SAL. The inverses of these probabilities are the respective base sampling weights of the SALs. The 20 selected VPs in each SAL had the same base weight. During the weighting procedures, the SAL base weight was first adjusted to correct for the valid and realised SALs. Secondly, the VP base weight was proportionally adjusted for the number of invalid and unrealised VPs in each SAL. Thirdly, the final VP sampling weight was computed as the product of the SAL sampling weight and the VP sampling weight.

In the final step, information at the individual level was integrated to calculate the final sampling weight for each data record. The individual weight was equal to the final SAL weight multiplied by the final VP sampling weight, adjusted for individual non-response. The final individual weights were benchmarked against Statistics South Africa's 2022 mid-year population estimates of adults aged 18 years and older by age group, race, sex and province.

2.7.3. Data analysis

Data analysis was performed on two separate datasets, one for men and one for women. Data analysis was performed using Stata version 18.0 and the figures were prepared in Microsoft Excel. A Chi-squared test for proportions was used to compare estimated proportions for categorical variables. The results depict weighted percentages, 95% confidence intervals and p-values. A p-value<5% indicates statistical significance. Unweighted counts (n) are reported, unless otherwise specified. The sum of the individual weighted counts may not sum to the overall total due to missing data for certain demographic variables. Weighted counts are sometimes presented in efforts to estimate the total number of women in the country who experienced forms of victimisation and the total number of men in the country who perpetrated violence.

The primary victimisation and perpetration outcomes of the study looked at the different manifestations of IPV among women and men who were or who had ever been in a relationship, married, co-habiting, or engaged to a male or female partner, respectively, (referred to as ever-partnered women and men) and included victim's experiences and perpetration of:

- lifetime and past 12 months physical violence
- lifetime and past 12 months sexual violence

Secondary outcomes of the study also explored experiences and perpetration of:

- lifetime and past 12 months emotional abuse
- lifetime and past 12 months economic abuse
- controlling behaviour by/towards an intimate partner

All reports of victimisation or perpetration in the past 12 months are referred to as recent acts in the results.

These outcomes were tabulated by socio-demographic and socio-behavioural factors. Pair-wise differences between estimates were considered statistically significant if their 95% confidence intervals did not overlap. Pearson Chi-squared tests were performed to assess the overall bivariate association between each type of violence perpetrated and the categorical variable of interest. Analysis was conducted on the weighted datasets and applied the 'svy' commands in Stata to incorporate the complex sample design.

The questionnaire items and response options differed between the questionnaires for men and women, so the socio-behavioural variables collected in the study also differ for men and women. Due to the different questionnaires used, items used to compute composite variables differed between men and women. We refer the reader to Appendix B and Appendix C for detailed variable definitions for the outcomes for victimisation and perpetration and the socio-demographic and socio-behavioural variables for women and men, respectively.

2.8. Ethical considerations

Ethical clearance to conduct the study was provided by the Research Ethics Committee at the Human Sciences Research Council (REC No 5/27/01/21) in July 2021 and renewed annually thereafter.

Due to the sensitive nature of the study, additional ethical considerations were implemented to ensure participant's privacy, safety and confidentiality. These are detailed in the questionnaire administration section.

Additional safety and ethical considerations included the following:

- All information sheets and consent forms were electronic, and no hard copies were left with participants in their households.
- Consent was obtained verbally and recorded electronically, leaving no hard copies in the household. Participants were not required to sign an informed consent, as per the WHO guidelines. This is also aimed at ensuring that there is no breach of confidentiality, nor reduced disclosure, since the respondent might fear that someone could link their signature with the study and that her/his partner may find out, impacting the individual's safety and the data quality.
- No mention of GBV was made in any publicly available survey communication and a safe name was used for the study.
- Overall, the questionnaires were interviewer-administered but the most sensitive sections in the men's questionnaire were self-administered.
- All interviews took place in private and secure spaces within the household. Where interruptions occurred interviewers were trained to change the topic of the interview to maintain privacy or terminate the interviews where privacy was compromised.

2.9. Implementation challenges

The implementation phase of this study encountered numerous challenges, which are briefly described below:

- **Training and rollout delays:** COVID-19 restrictions hindered the ability to train fieldworkers and execute the study as planned. Consequently, the study was delayed, implemented in phases, took longer to implement, and costs were escalated.
- **Fieldwork challenges:** Once fieldwork began, several unforeseen challenges arose. These included difficulties in staffing the project, particularly among male, white, and Indian staff members. High staff turnover within the project team also presented significant challenges. Staffing challenges and the high turnover was more prominent due to the implementation of three other national surveys during the same period, namely: The 6th National HIV Prevalence Survey, the National Food and Nutrition Security Survey, and the National Census by Stats SA.
- **Socio-political and environmental factors:** The political unrest in KZN and Gauteng during July 2021, the high crime rate, violence, natural disasters such as the floods in KZN and the Eastern Cape in April 2022, and changing community dynamics further complicated the implementation of the survey.
- **Spread of misinformation:** Fake news or false reports about data collectors entering homes and robbing residents that were spread by social media compromised staff safety and, in some provinces, delayed data collection. The HSRC's communications team and the core research team worked hard to combat the spread of fake news that had started in one province but was quickly spread nationally through social media. The HSRC had to use all available platforms, including the police, community leaders, community safety forums, and government officials, to restore community trust and allow field staff to resume data collection.
- **Incomplete data collection due to funding constraints:** By the end of December 2022, data collection ceased with critical gaps in the white areas in the Western Cape, Indian community in Gauteng and farming communities in the Eastern and Western Cape. These areas were later included in the study once additional funding was secured. Data collection to complete the critical areas where data had not been collected, could only resume at the end of November 2023 and concluded in February 2024.
- **COVID-19-related expenses:** The pandemic negatively impacted the collection of data. It slowed the study and added costs that were not anticipated during the planning phases. Such expenses included delays in procuring of study materials due to global supply chain disruptions and price increases linked to the supply and demand of goods, multiple training sessions due to the limited number of participants that could be accommodated in one venue during lockdown, extra cars to accommodate numbers of passengers allowed per vehicle, and extended use of personal protective equipment (PPE). Fear of infection with COVID-19 was high which increased anxiety among communities, field teams, and managers. Affected staff members often battled long-term physical and mental health impacts.
- **Safety issues and crime levels:** Safety concerns made it necessary to engage community liaison officers and, at times, utilise the services of local security personnel to assist data collectors to access homes and increase patrols in the SALs. This also strained the study's finances.

CHAPTER 3

RESULTS

3.1. Response rates

The household and individual response rates by province are presented in Table 2 and Table 3. During data collection, some selected households or VPs were found to be invalid. Invalid VPs were those that had been destroyed or vacated, or the sampled building was found to be a non-residential structure such as a business enterprise. Invalid VPs were not included in the response analysis at the household level. The household response rate was defined as the number of valid VPs that completed interviews divided by the number of valid VPs. The survey selected 1 096 SALs, of which 548 were allocated for data collection for women and 548 for men. Within each SAL, the survey targeted 20 VPs resulting in a total of 10 960 VPs each for the women and men samples.

In the women's SALs, 10 183 VPs were approached of which 9 317 (91.5%) were valid. A total of 5 840 VPs agreed to participate and completed a household screening questionnaire in which they listed all the women residing in the VP with their ages. Of these 5 840 VPs, 5 768 were found to have women aged 18 years and older residing in the household. This resulted in a household response rate of 61.9%. Household response rates for women were highest in KwaZulu-Natal (74.5%) followed by the Eastern Cape (73.8%), and were lowest in the Northern Cape (45.1%). Among these 5 768 VPs, there were 8 896 women aged 18 years and older who could be interviewed. Only one woman was selected to be interviewed per VP. Therefore, the individual response rate is calculated as the number of women participating divided by the number of households with women aged 18 years and older. A total of 5 603 women agreed to be interviewed from the 5 768 VPs (97.1%).

In the men's SALs, only 9 623 VPs were approached of which 8 864 (92.1%) were valid. A total of 4 924 VPs agreed to participate and completed a household screening questionnaire in which they listed all the men residing in the VP with their ages. Of these 4 924 VPs, 4 668 were found to have men aged 18 years and older residing in the household, resulting in a household response rate of 52.7%. Household response rates for men were highest in the Free State (60.6%), Mpumalanga (60.5%) and Limpopo (60.5%) and lowest in the Western Cape (44.3%). Among these 4 668 VPs, there were 6 182 men aged 18 years and older, of which a total of 4 409 agreed to be interviewed (94.5%). This is considerably higher than the 70% assumed during sample size estimation.

Table 2: Household and individual sample realised and response rate for women aged 18 years and older by province

	SALs sampled	Number of households visited	Number of valid households	Number of households who completed the household screening[1]	Number of households with women aged 18 years and older[2]	Household response rate[3] (%)	Number of women participated	Individual response rate[4] (%)
National	548	10 183	9 317	5 840	5 768	61.9%	5 603	97.1%
Province								
Western Cape	70	1 167	1 089	526	526	48.3%	512	97.3%
Eastern Cape	73	1 413	1 271	938	938	73.8%	936	99.8%
Northern Cape	42	953	821	370	370	45.1%	370	100.0%
Free State	41	818	758	476	469	61.9%	429	91.5%
KwaZulu-Natal	102	1 806	1 674	1 286	1 247	74.5%	1 192	95.6%
North West	41	750	680	443	442	65.0%	441	99.8%
Gauteng	96	1 680	1 586	865	849	53.5%	808	95.2%
Mpumalanga	40	737	648	420	415	64.0%	412	99.3%
Limpopo	43	859	790	516	512	64.8%	503	98.2%

1. Household screening involved capturing information on age and residence for all women in the household to ascertain their eligibility;
2. Meeting eligibility criteria detailed in the sampling methodology; 3. Number of households with women aged 18 years and older divided by the number of valid households; 4. Number of women participating divided by the number of households with women aged 18 years and older.

Table 3: Household and individual sample realised and response rate for men aged 18 years and older by province

	SALs sampled	Number of households visited	Number of valid households	Number of households who completed the household screening[1]	Number of households with men aged 18 years and older[2]	Household response rate[3] (%)	Number of men participated	Individual response rate[4] (%)
National	548	9 623	8 864	4 924	4 668	52.7%	4 409	94.5%
Province								
Western Cape	71	1 286	1 238	579	548	44.3%	540	98.5%
Eastern Cape	71	1 182	1 098	559	550	50.1%	541	98.4%
Northern Cape	43	687	609	322	313	51.4%	308	98.4%
Free State	41	621	556	371	337	60.6%	295	87.5%
KwaZulu-Natal	97	1 754	1 637	866	825	50.4%	807	97.8%
North West	41	762	709	384	384	54.0%	384	100.0%
Gauteng	97	1 817	1 674	965	899	53.7%	767	85.3%
Mpumalanga	42	665	583	389	353	60.5%	337	95.5%
Limpopo	45	849	760	489	460	60.5%	430	93.5%

1. Household screening involved capturing information on age and residence for all men in the household to ascertain their eligibility; 2. Meeting eligibility criteria detailed in the sampling methodology; 3. Number of households with men aged 18 years and older divided by the number of valid households; 4. Number of men participating divided by the number of households with men aged 18 years and older.

Appendix E shows a comparison of the socio-demographic characteristics of the survey sample with the Stats SA mid-year population estimates of 2022 for people aged ≥18 years. The weighted survey sample closely resembles the 2022 population in terms of sex, age, race and province.

3.2. Characteristics of the study sample

3.2.1. Socio-demographic characteristics of study participants

From the total of 10 012 respondents who agreed to participate, 5 603 were women and 4 409 were men (Table 4). The majority were Black African (79.2% among women and 78.9% among men). Over 60% of both women and men had secondary school education as their highest education attainment (61.6% among women and 68.3% among men). With regard to employment status, 36.0% percent of women were employed and 56.7% of men were employed. The majority of women were ever-partnered, (92.2%) and 62.7% were currently in a relationship. Among men, 80.1% were ever-partnered and 76.0% were currently in a relationship. The majority (over 67%) of participants (both women and men) were residing in urban areas. Large proportions of women and men who participated in the study were from Gauteng and KwaZulu-Natal provinces.

Participants were asked to indicate the gender with which they identified. In the women sample, 99.0% identified as women (n=5 546), followed by 0.4%, 0.3%, 0.1% and 0.1% who identified as men, non-binary gender, did not identify with any of the listed options and transwomen respectively. In the men sample, 99.0% (n=4 353) identified as men, followed by 1.0% and <0.1% who identified as women and transwomen respectively.

The main income sources for women and men are shown in Figure 4 and Figure 5 respectively. Questions on income were asked differently in the men and women questionnaires. There were two questions in the men's questionnaire pertaining to income sources, namely who provided the main source of income in the home and what was their main source of income the previous month (see Appendix C). Among men, 45.9% reported that the main source of income in their home was provided by themselves, while 13.8% reported that it was provided equally by their partner and themselves (Figure 5). The women's questionnaire provided a comprehensive list of possible sources of income. When these were analysed we found that, 28.1% of women indicated that their main source of income was a government grant, 25.2% reported receiving money from their own work, 12.1% reported receiving financial support from their partners and 9.4% reported having no income (Figure 4).

Table 4: Socio-demographic characteristics of study participants aged 18 years and older by sex, South Africa, 2022

	Women			Men		
	n	%	95% CI	n	%	95% CI
Total	5 603	100.0		4 409	100.0	
Age group						
18–24	587	15.9	[14.2-17.8]	682	17.7	[15.9-19.6]
25–34	1 189	25.8	[23.9-27.7]	1 103	27.6	[25.6-29.7]
35–49	1 634	28.9	[27.2-30.8]	1 355	30.9	[29.0-32.9]
50+	2 191	29.4	[27.5-31.3]	1 267	23.8	[21.8-25.9]
Race						
Black African	4 255	79.2	[76.0-82.1]	3 562	78.9	[75.5-82.0]
White	287	8.8	[6.7-11.6]	197	8.8	[6.6-11.8]
Coloured	740	8.6	[7.0-10.6]	532	8.1	[6.4-10.3]
Indian/Asian	304	3.1	[2.2-4.2]	99	3.4	[2.1-5.3]
Other	7	0.3	[0.1-0.8]	17	0.7	[0.3-1.5]
Highest level of education						
No formal schooling	313	4.2	[3.5-5.0]	97	1.6	[1.2-2.2]
Primary school	836	11.1	[10.0-12.3]	671	12.3	[11.0-13.8]
Secondary school	3 472	61.6	[59.2-64.0]	2 889	68.3	[66.0-70.5]
Tertiary	959	23.1	[20.6-25.8]	638	17.7	[15.6-20.1]
Employment status						
Unemployed	3 123	64.0	[61.3-66.6]	1 705	43.3	[40.6-46.1]
Employed	1 810	36.0	[33.4-38.7]	2 642	56.7	[53.9-59.4]
Ever-partnered						
Yes	5 157	92.2	[90.9-93.4]	3 524	80.1	[78.1-81.9]
No	360	7.8	[6.6-9.1]	772	19.9	[18.1-21.9]
Current relationship status						
Currently married	1 945	32.1	[29.7-34.5]	1 407	30.4	[28.0-32.9]
Cohabiting, not married	584	9.0	[7.9-10.2]	607	12.4	[10.9-14.0]
Partner, not cohabiting	954	21.6	[19.7-23.6]	1 318	33.2	[30.8-35.7]
No relationship	2 023	37.3	[35.1-39.6]	966	24.1	[22.1-26.2]
Locality type						
Urban	3 988	70.1	[65.3-74.5]	2 738	67.2	[62.9-71.3]
Rural informal (tribal areas)	1 091	26.4	[22.1-31.3]	933	27.3	[23.2-31.7]
Rural formal (farms)	524	3.5	[2.3-5.2]	738	5.5	[4.1-7.4]
Province						
Western Cape	512	12.8	[11.4-14.3]	540	12.8	[11.5-14.3]
Eastern Cape	936	11.4	[10.2-12.8]	541	10.5	[9.2-11.9]
Northern Cape	370	2.1	[1.7-2.6]	308	2.1	[1.6-2.7]
Free State	429	4.9	[4.2-5.6]	295	4.6	[3.9-5.4]
KwaZulu-Natal	1 192	20.2	[17.8-22.7]	807	19.1	[17.2-21.3]
North West	441	5.8	[4.6-7.3]	384	6.1	[5.4-6.9]
Gauteng	808	24.6	[22.3-27.1]	767	27.6	[25.5-29.8]
Mpumalanga	412	8.1	[6.9-9.6]	337	7.9	[6.9-9.1]
Limpopo	503	10.1	[8.4-12.1]	430	9.2	[7.8-10.9]

Figure 4: Main source of income for women aged 18 years and older and their households, South Africa 2022

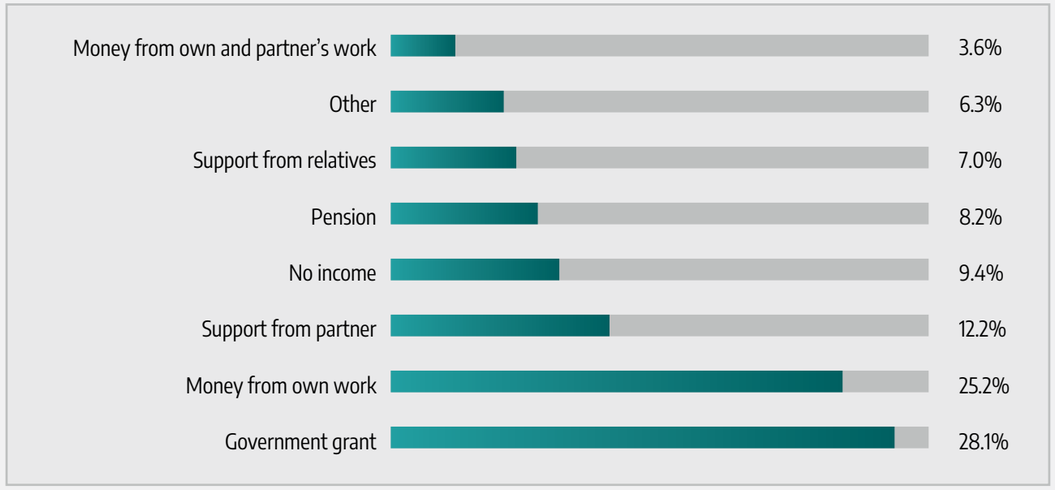
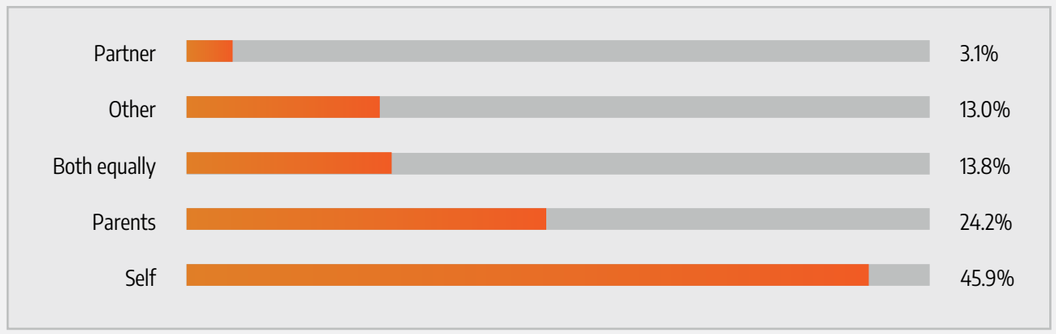


Figure 5: Main source or main provider of income in the home as reported by men aged 18 years and older, South Africa 2022



3.2.2. Marriage characteristics among women and men who were ever married

The study also explored marital arrangements. Women who were ever married or lived with a partner and men who were ever married were asked questions about their marriage/s (see table in Appendix F). Among women who were ever married or had lived with a partner (n=2 219), 8.6% reported being younger than 18 years of age when they were first married or lived together with a man, while 45.3% were between 18 and 24 years old. A further 8.0% reported that their husband or partner had other partners while they were married or in a relationship with them.

Among ever-married men (n=1 752), 1.2% reported being younger than 18 years at the time they first got married, while 76.2% were 25 years or older when they were first married (see table in Appendix G). While the majority (89.3%) reported that they mutually chose to marry their current or most recent wife, 4.2% reported that they had an arranged marriage. A further 5.4% reported that their marriage was negotiated with elders and their partner had to agree, and 1.1% reported that they were married through *ukuthwala*. Polygamy was reported by less than 3.0% of ever-married men, and 67.3% reported that their marriage involved a *lobola* or dowry payment.

3.2.3. Socio-behavioural characteristics, psychological status and childhood experiences

The study collected data pertaining to participants' socio-behavioural characteristics. Items measured included substance use, condom use, number of sexual partners, psychological status (general mental health, depression, suicidal ideation, and anxiety), and a history of childhood trauma. Furthermore, there were modules that measured gender-related norms, attitudes and gendered power relations as well as food insecurity.

Table 5 presents the socio-behavioural characteristics of ever-partnered women. Nearly 40% of ever-partnered women reported that they had two or three lifetime sexual partners. In total, 80.1% reported not using condoms as a contraceptive method currently. More than 60% of ever-partnered women reported that they never consume alcohol and 96.6% reported that they had never used drugs. Regarding mental health, 23.1% had scores that indicated that they could be classified as having current mild anxiety, 34.4% had scores indicative of minimal depression, and 11.8% had a history of suicidal ideation. Regarding childhood experiences before the age of 15, 58.6% of ever-partnered women reported a history of physical abuse, 4.2% reported a history of sexual abuse, and 11.8% reported a history of emotional abuse, while 21.7% reported that their mother had been physically abused by a partner. A relatively large proportion (46.5%) of ever-partnered women reported that people in their home recently went without food at times because of lack of money.

Table 6 presents the socio-behavioural characteristics of ever-partnered men. More than half the ever-partnered men (53.5%) reported that their most recent or current partner was within five years of their age, while 45.0% reported that their most recent or current partner was more than five years younger than them. Just over a third (36.8%) of ever-partnered men reported having ever engaged in transactional sex for which they provided or were expected to provide payments or items for their partner, and 69.8% had had more than four sexual partners during their lifetime. In total, 25.0% of men had scores that were indicative of being at risk for clinical depression in the two weeks prior to being interviewed, 11.8% had a history of suicidal ideation during their lifetime, 4.6% had a history (ever) of attempted suicide, 36.6% had lower scores on the current satisfaction with life scale, and 9.3% of men had lower scores for levels of empathic concern currently. Over a fifth (22.8%) of men had high levels of childhood trauma, 30.4% reported that they were bullied, teased or harassed while growing up, and 17.8% had bullied teased or harassed others. About 29.6% of ever-partnered men reported that people in their homes had recently gone without food at times due to a lack of money.

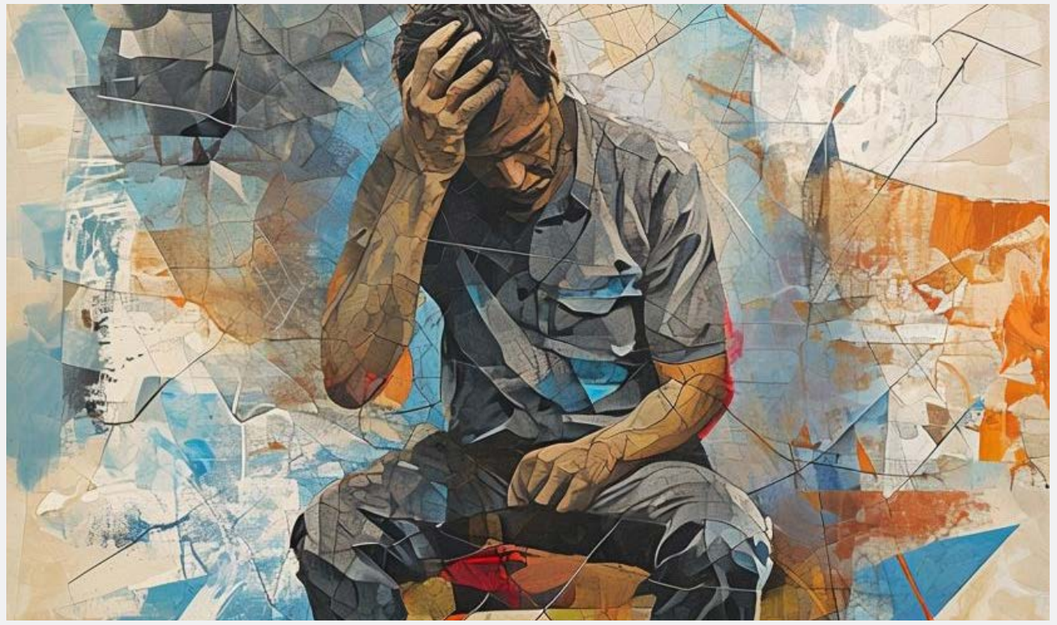


Table 5: Socio-behavioural characteristics, psychological status and childhood experiences among ever-partnered women aged 18 years and older, South Africa, 2022

	Ever-partnered women		
	n	%	95% CI
SEXUAL BEHAVIOUR			
Number of sexual partners in one's lifetime			
1 partner	1 610	29.8	[27.8-31.9]
2–3 partners	1 961	39.5	[37.5-41.7]
4+ partners	1 427	30.6	[28.5-32.9]
Current condom use			
Yes	846	19.9	[18.0-22.0]
No	4 311	80.1	[78.0-82.0]
SUBSTANCE USE			
Current frequency of alcohol intake			
Never	3 385	62.4	[59.8-64.9]
Less than once a month	615	13.7	[12.2-15.4]
1–3 times a month	616	12.7	[11.2-14.4]
Once or twice a week	426	9.6	[7.8-11.7]
Every day	100	1.6	[1.2-2.2]
Drug use during one's lifetime			
Yes	142	3.4	[2.6-4.4]
No	4 984	96.6	[95.6-97.4]
MENTAL HEALTH			
Generalised anxiety disorder			
Minimal anxiety	3 334	67.9	[65.7-70.1]
Mild anxiety	1 181	23.1	[21.3-25.0]
Moderate anxiety	260	5.4	[4.4-6.6]
Severe anxiety	172	3.6	[2.9-4.6]
Depression (Patient Health Questionnaire-9 - PHQ-9)			
Not at all	1 524	29.2	[27.0-31.5]
Minimal depression	1 556	34.4	[32.2-36.6]
Mild depression	1 214	25.3	[23.4-27.2]
Moderate depression	316	6.4	[5.4-7.7]
Moderately severe depression	125	2.7	[2.1-3.6]
Severe depression	103	2.0	[1.5-2.7]
Ever had suicidal ideation			
Yes	531	11.8	[10.4-13.5]
No	4 601	88.2	[86.5-89.6]

	Ever-partnered women		
	n	%	95% CI
CHILDHOOD EXPERIENCES			
History of childhood physical abuse			
Yes	2 686	58.6	[55.8-61.3]
No	2 059	41.4	[38.7-44.2]
History of childhood sexual abuse			
Yes	162	4.2	[3.2-5.5]
No	4 952	95.8	[94.5-96.8]
History of childhood emotional abuse			
Yes	509	11.8	[10.3-13.6]
No	4 479	88.2	[86.4-89.7]
Reported that mother was physically abused by a partner			
Yes	1 027	21.7	[19.7-23.8]
No	3 523	78.3	[76.2-80.3]
NORMS AND ATTITUDES			
Gender relations			
Low equity	1 724	32.7	[30.5-35.1]
Medium equity	1 725	35.0	[33.0-37.1]
High equity	1 536	32.2	[29.9-34.6]
Attitudes towards gendered power relations			
Agree	87	1.4	[1.1-1.9]
Somewhat agree	50	0.8	[0.6-1.2]
Disagree	5 005	97.8	[97.2-98.2]
OTHER			
Food insecurity			
Yes	2 443	46.5	[43.9-49.2]
No	2 513	53.5	[50.8-56.1]
Quarrel with partner			
Rarely	1 888	48.0	[45.0-51.0]
Sometimes	1 314	39.2	[36.3-42.2]
Often	487	12.8	[11.3-14.5]

Table 6: Socio-behavioural characteristics, psychological status and childhood experiences among ever-partnered men aged 18 years and older, South Africa, 2022

	Ever-partnered men		
	n	%	95% CI
SEXUAL BEHAVIOUR			
Most recent or current partner's age			
Partner is >5 years older	58	1.5	[1.1-2.1]
Partner is >5 years younger	1 548	45.0	[42.3-47.6]
Partner within 5 years older or younger	1 640	53.5	[50.9-56.2]
Transactional sex			
Ever engaged in transactional sex	1 195	36.8	[34.1-39.5]
Never engaged in transactional sex	2 020	63.2	[60.5-65.9]
Number of sexual partners in one's lifetime			
1 partner	352	11.9	[10.2-13.8]
2–3 partners	649	18.3	[16.4-20.4]
4+ partners	2 392	69.8	[67.2-72.2]
SUBSTANCE USE			
Hazardous drinking or active alcohol use disorders (AUDIT-C)			
No hazardous drinking	1 711	49.8	[47.1-52.4]
Hazardous drinking	1 671	50.2	[47.6-52.9]
Drug use (past 12 month)			
Did not use drugs	3 069	91.9	[90.3-93.2]
Used drugs	248	8.1	[6.8-9.7]
MENTAL HEALTH			
Centre for Epidemiologic Studies Depression Scale (CES-D)			
Not at risk for clinical depression	2 382	75.0	[72.5-77.3]
At risk for clinical depression	810	25.0	[22.7-27.5]
Ever suicidal ideation			
No	3 079	88.2	[86.5-89.7]
Yes	392	11.8	[10.3-13.5]
Ever attempted suicide			
No	3 320	95.4	[94.2-96.3]
Yes	151	4.6	[3.7-5.8]
Satisfaction with Life			
Higher/neutral	2 152	63.4	[60.6-66.2]
Lower	1 302	36.6	[33.8-39.4]
Empathic Concern			
Lower empathic concern	345	9.3	[7.8-11.0]
Higher empathic concern	3 098	90.7	[89.0-92.2]
CHILDHOOD TRAUMA			
Childhood trauma scale			
Low (0–3)	1 518	50.0	[47.1-52.9]
Medium (4–6)	945	27.2	[24.9-29.6]
High (7+)	887	22.8	[20.8-25.0]
Bullied, teased or harassed			
No	2 293	69.6	[67.1-72.1]
Yes	1 122	30.4	[27.9-32.9]
Bullied, teased or harassed others			
No	2 711	82.2	[80.3-84.0]
Yes	696	17.8	[16.0-19.7]
GENDER-RELATED NORMS AND ATTITUDES			
Gender-related norms (higher = more inequitable)			
Low	1 340	44.2	[41.5-47.0]
Medium	1 323	36.1	[33.7-38.6]
High	744	19.7	[17.7-21.9]
Attitudes towards gendered power relations (higher = more inequitable)			
Low	1 388	43.1	[40.6-45.7]
Medium	879	27.3	[25.0-29.7]
High	1 060	29.6	[27.1-32.2]
OTHER			
Food insecurity			
No	2 314	70.4	[67.9-72.8]
Yes	1 083	29.6	[27.2-32.1]

Centre for Epidemiologic Studies Depression scale (CES-D) - questions asked men to reflect on the past week
Satisfaction with Life - current
Empathic concern scale - current
Food insecurity: every week, every month but not every week, it happens but not every month, never.

3.3. Prevalence of lifetime physical and sexual violence among women regardless of partnered status

Lifetime experiences of victimisation of physical and sexual violence are presented in three categories. The results of women who experienced physical violence are presented first, followed by the results of those who experienced sexual violence. The results of women who experienced physical violence and/or sexual violence are reported last.

3.3.1. Prevalence of lifetime physical violence regardless of partnered status

Overall, 33.1% [95% CI: 30.8-35.5] of women reported experiencing lifetime physical violence (Table 7). This translates to an estimated 7 310 389 women who experienced physical violence during their lifetime (Appendix H). The proportion of women who reported experiencing lifetime physical violence varied significantly by age, race, current relationship status, and locality. Lifetime physical violence victimisation ranged from 28.5% among women aged 50 years and older, to 35.6% among women aged 35–49 years. More women residing in urban areas had experienced lifetime physical violence than their rural area counterparts. A significantly higher proportion of Black African women experienced lifetime physical violence than women of other race groups. Furthermore, a significantly higher proportion of women who were cohabiting but not married had experienced physical violence in their lifetime, compared to women who were currently married and those who were not currently in a relationship.

3.3.2. Prevalence of lifetime sexual violence regardless of partnered status

In total, 9.8% [95% CI: 8.6-11.1] of all women reported that they had experienced sexual violence in their lifetime (Table 7). This translates to an estimated 2 150 342 women who have been sexually violated in their lifetime (Appendix H). Lifetime sexual violence victimisation varied significantly by employment and current relationship status. A higher proportion of women who were employed had experienced sexual violence in their lifetime, compared to women who were unemployed. A significantly higher proportion of women who were cohabiting and not married had experienced sexual violence in their lifetime, compared to women who were currently married.

3.3.3. Prevalence of lifetime physical and/or sexual violence regardless of partnered status

Overall, 35.5% [95% CI: 33.2-37.9] of women reported experiencing lifetime physical and/or sexual violence (Table 7). This translates to an estimated 7 847 438 women who experienced physical and/or sexual violence during their lifetime (Appendix H). Lifetime physical and/or sexual violence victimisation varied significantly by age, race, employment and current relationship status. The proportion of women who reported having ever experienced physical and/or sexual violence during their lifetime, ranged from 30.5% among women aged 50 years and older to 38.0% among women aged 35–49 years. A significantly higher proportion of Black African women experienced physical and/or sexual violence compared to women of other race groups. A significantly higher proportion of women who were cohabiting and not married had experienced physical and/or sexual violence in their lifetime, compared to women who were currently married and those who were not currently in a relationship. A higher proportion of women who were employed had experienced physical and/or sexual violence in their lifetime compared to women who were unemployed.

Furthermore, 58.0% [95% CI: 55.2-60.8] of women reported a history of physical childhood abuse before age 15, which translates to an estimated 11 996 096 women who reported being physically abused as children (Appendix J). Furthermore, 4.0% [95% CI: 3.1-5.2] of women reported a history of sexual child abuse before age 15 years, which translates to an estimated 880 530 women (Appendix J).

Table 7: Percentage of all women aged 18 years and older who reported ever experiencing physical and/or sexual violence by intimate partners or non-partners in their lifetime, South Africa, 2022

	Ever experienced any physical violence[1]				Ever experienced any sexual violence[2]				Ever experienced any physical and/or sexual violence[3]			
	%	95% CI	n	p-value	%	95% CI	n	p-value	%	95% CI	n	p-value
Total	33.1	[30.8-35.5]	5 557		9.8	[8.6-11.1]	5552		35.5	[33.2-37.9]	5561	
Age group				0.023				0.138				0.013
18–24	34.8	[29.5-40.6]	584		7.5	[5.1-11.1]	582		37.9	[32.5-43.7]	584	
25–34	34.6	[30.6-38.7]	1 178		10.4	[8.1-13.4]	1 177		36.9	[33.0-41.1]	1 179	
35–49	35.6	[31.9-39.4]	1 626		11.3	[9.3-13.7]	1 626		38.0	[34.3-41.9]	1 627	
50+	28.5	[25.3-31.9]	2 169		8.8	[7.3-10.5]	2 167		30.5	[27.3-34.0]	2 171	
Race				<0.001				0.159				<0.001
Black African	35.5	[32.9-38.1]	4 220		10.2	[8.9-11.7]	4 216		37.9	[35.3-40.6]	4 224	
Other race	23.9	[19.7-28.6]	1 322		8.2	[6.1-10.9]	1 321		26.3	[22.0-31.0]	1 322	
Highest level of education				0.470				0.299				0.584
No formal schooling	28.5	[21.3-36.9]	309		5.9	[3.3-10.4]	311		31.4	[23.8-40.0]	311	
Primary school	35.9	[31.0-41.2]	831		8.5	[6.4-11.1]	831		37.9	[32.9-43.1]	832	
Secondary school	32.6	[29.9-35.4]	3 453		9.9	[8.4-11.7]	3448		35.1	[32.4-37.9]	3 454	
Tertiary	34.0	[29.5-38.8]	954		10.7	[8.2-13.8]	952		36.4	[31.9-41.3]	954	
Employment status				0.085				0.003				0.047
Unemployed	32.0	[29.1-35.1]	3 103		8.7	[7.2-10.4]	3 102		34.2	[31.3-37.4]	3 107	
Employed	35.9	[32.5-39.3]	1 799		12.4	[10.4-14.7]	1798		38.7	[35.3-42.1]	1 799	
Current relationship status				<0.001				0.025				<0.001
Currently married	29.6	[26.3-33.1]	1 941		8.5	[7.0-10.3]	1 942		31.4	[28.1-34.8]	1 942	
Cohabiting, not married	43.4	[37.3-49.7]	581		14.9	[10.8-20.1]	580		47.9	[41.8-54.0]	582	
Partner, not cohabiting	37.2	[32.8-41.9]	948		9.9	[7.6-12.9]	947		39.8	[35.3-44.5]	948	
No relationship	30.6	[27.3-34.0]	2 006		9.6	[7.9-11.6]	2 001		32.9	[29.6-36.5]	2 007	
Locality type				0.044				0.053				0.058
Urban	34.7	[32.0-37.6]	3 957		10.5	[9.1-12.2]	3 951		37.1	[34.3-40.0]	3 959	
Rural informal (tribal areas)	29.1	[25.1-33.6]	1 082		8.1	[6.3-10.5]	1 081		31.7	[27.3-36.4]	1 082	
Rural formal (farms)	30.3	[23.9-37.5]	518		6.2	[4.0-9.5]	520		32.2	[25.8-39.4]	520	

1. Any one or more of the following: a) slapped you or thrown something at you that could hurt you; b) pushed you or shoved you or pulled your hair; c) hit you with his fist or with something else that could hurt you; d) kicked you; dragged you or beat you up; e) choked or burnt you on purpose; f) threatened with or actually used a gun; knife or other weapon against you;
2. Any one or more of the following: a) force you to have sexual intercourse when you did not want to; for example by threatening you or holding you down; b) ever have sexual intercourse you did not want to because you were afraid of what your partner might do if you refused; c) force you to do anything else sexual that you did not want or that you found degrading or humiliating;
3. 1 and/or 2.

3.4. Recent physical and sexual violence among women regardless of partnered status

3.4.1. Prevalence of recent physical violence regardless of partnered status

Overall, 6.1% [95% CI: 5.1-7.3] of women had experienced physical violence in the preceding 12 months (Table 8), which translates to an estimated 1 338 336 women who experienced physical violence recently (Appendix H). Recent experiences of physical violence varied significantly by age, race, current relationship status and locality type. Significantly more of women aged 18–24, 25–34 and 35–49 years, (10.6%, 7.9% and 5.8%, respectively), had experienced physical violence in the past 12 months than those aged 50 years and older (2.2%). A higher proportion of Black African women had experienced recent physical violence than women from other race groups. Women residing in urban areas were significantly affected by recent physical violence compared to women living in rural formal and rural informal locality types. A significantly higher proportion of women who were cohabiting and not married had experienced physical violence in the past 12 months than women who were currently married and those who were not currently in a relationship.

3.4.2. Prevalence of recent sexual violence regardless of partnered status

An estimated 2.0% [95% CI: 1.5-2.5] of all women had experienced recent sexual violence (Table 8), which translates to an estimated 432 525 women who had experienced sexual violence in the previous 12 months (Appendix H). Recent sexual violence victimisation varied significantly by age, race and current relationship status. A significantly higher proportion of women aged 25 – 34 (2.6%) and 35 – 49 years (2.6%) had experienced recent sexual violence than those aged 50 years and older (0.9%). A higher proportion of Black African women reported experiencing recent sexual violence compared to other race groups. A significantly higher proportion of women who were cohabiting and not married had experienced sexual violence in the past 12 months, compared to women who were not currently in a relationship.

3.4.3. Prevalence of recent physical and/or sexual violence regardless of partnered status

In total 7.0% [95% CI: 5.9-8.2] of women, reported experiencing recent physical and/or sexual violence, which translates to an estimated 1 536 729 women (Table 8 and Appendix H). Recent physical and/or sexual violence victimisation differed significantly by age, race, current relationship status and locality type. A significantly higher proportion of women aged 18–24 (11.3%), 25–34 (9.0%) and 35–49 years (6.9%) reported experiencing physical and/or sexual violence in the previous 12 months compared to women aged 50 years and older (2.9%). A significantly higher proportion of Black African women reported experiencing recent physical and/or sexual violence recently compared to women from other race groups. A significantly higher proportion of women who were cohabiting and not married had experienced physical and/or sexual violence in the preceding 12 months compared to women who were currently married and those who were not currently in a relationship. A higher proportion of women residing in urban areas reported they had recently experienced physical and/or sexual violence, compared to their counterparts residing in rural informal (tribal areas) (Table 8).

Table 8: Percentage of all women aged 18 years and older who reported experiencing physical and/or sexual violence by intimate partner(s) or non-partner(s) in the past 12 months, South Africa, 2022

	Recently experienced any physical violence[1]				Recently experienced any sexual violence[2]				Recently experienced any physical and/or sexual violence[3]			
	%	95% CI	n	p-value	%	95% CI	n	p-value	%	95% CI	n	p-value
Total	6.1	[5.1-7.3]	5 553		2.0	[1.5-2.5]	5 550		7.0	[5.9-8.2]	5 560	
Age group				<0.001				0.018				<0.001
18-24	10.6	[7.1-15.4]	583		1.8	[0.9-3.5]	582		11.3	[7.8-16.1]	584	
25-34	7.9	[6.0-10.5]	1 178		2.6	[1.7-4.0]	1 176		9.0	[7.0-11.6]	1 179	
35-49	5.8	[4.4-7.7]	1 625		2.6	[1.8-3.7]	1 625		6.9	[5.3-8.9]	1 627	
50+	2.2	[1.3-3.8]	2 167		0.9	[0.5-1.6]	2 167		2.9	[1.9-4.5]	2 170	
Race				0.019				0.026				0.006
Black African	6.6	[5.5-8.1]	4 217		2.2	[1.7-2.9]	4 214		7.7	[6.4-9.1]	4 224	
Other race	3.9	[2.6-5.9]	1 321		1.0	[0.5-2.0]	1 321		4.3	[2.9-6.3]	1 321	
Highest level of education				0.307				0.070				0.206
No formal schooling	4.6	[0.9-20.0]	309		0.0		311		4.6	[0.9-20.0]	311	
Primary school	4.9	[2.9-8.1]	830		1.9	[1.1-3.2]	831		5.9	[3.6-9.4]	832	
Secondary school	7.0	[5.8-8.5]	3 450		2.4	[1.8-3.2]	3 446		8.1	[6.8-9.7]	3 453	
Tertiary	4.3	[2.6-7.1]	954		1.2	[0.6-2.4]	952		4.8	[3.0-7.6]	954	
Employment status				0.592				0.610				0.593
Unemployed	6.1	[4.8-7.7]	3 099		2.0	[1.4-2.8]	3 102		7.1	[5.7-8.8]	3 106	
Employed	5.5	[4.1-7.4]	1 799		2.3	[1.5-3.4]	1 796		6.4	[4.9-8.4]	1 799	
Current relationship status				<0.001				0.002				<0.001
Currently married	4.2	[2.9-5.9]	1 941		2.0	[1.3-3.1]	1 942		5.3	[3.9-7.2]	1 942	
Cohabiting, not married	11.2	[8.0-15.6]	580		4.0	[2.5-6.5]	580		12.3	[9.0-16.6]	581	
Partner, not cohabiting	8.5	[6.3-11.3]	948		2.6	[1.6-4.4]	946		9.8	[7.5-12.8]	948	
No relationship	5.0	[3.4-7.3]	2 005		0.9	[0.5-1.7]	2 000		5.4	[3.7-7.6]	2 007	
Locality type				0.015				0.590				0.009
Urban	6.9	[5.6-8.5]	3 953		2.1	[1.6-2.8]	3 950		7.9	[6.6-9.5]	3 958	
Rural informal (tribal areas)	3.9	[2.5-5.9]	1 082		1.7	[1.0-2.9]	1 081		4.4	[3.0-6.6]	1 082	
Rural formal (farms)	5.6	[3.5-8.6]	518		1.9	[1.0-3.7]	519		6.5	[4.2-9.9]	520	

1. Any one or more of the following: a) slapped you or thrown something at you that could hurt you; b) pushed you or shoved you or pulled your hair; c) hit you with his fist or with something else that could hurt you; d) kicked you; dragged you or beat you up; e) choked or burnt you on purpose; f) threatened with or actually used a gun; knife or other weapon against you;
2. Any one or more of the following: a) force you to have sexual intercourse when you did not want to; for example by threatening you or holding you down; b) ever have sexual intercourse you did not want to because you were afraid of what your partner might do if you refused; c) force you to do anything else sexual that you did not want or that you found degrading or humiliating;
3. 1 and/or 2.

3.5. Lifetime physical and sexual violence among intimate partners (IPV)

Lifetime experiences of victimisation and perpetration of physical and sexual IPV are presented in three categories for ever-partnered women and men. The results of women who experienced and men who perpetrated any physical IPV are presented first. This is followed by the results of women who experienced and men who perpetrated any sexual IPV. The results of women who experienced and men who perpetrated physical and/or sexual IPV are reported last.

3.5.1. Prevalence of lifetime physical IPV

Overall, 22.4% [95% CI: 20.1-24.7] of ever-partnered women reported experiencing physical IPV in their lifetime (Table 9), which translates to an estimated 3 221 649 ever-partnered women who have experienced lifetime physical IPV (Appendix H). The proportion of women who reported experiencing physical IPV in their lifetime varied significantly by race and current relationship status. A significantly higher proportion of women who were cohabiting with a partner and not married had experienced physical IPV in their lifetime, compared to women who were currently married.

Overall, 16.7% [95% CI: 14.8-18.7] of ever-partnered men reported perpetrating physical IPV in their lifetime (Table 10), which translates to an estimated 2 495 451 ever-partnered men who reported perpetrating physical IPV in their lifetime (Appendix I). Lifetime physical IPV perpetration varied significantly by age, current relationship status, employment status, and locality type. Perpetration of lifetime physical IPV was significantly higher among 25–34-year-old men and 35–49-year-old men compared to 18–24-year-old men. A significantly higher proportion of men who were cohabiting with a partner and were not married reported lifetime physical IPV perpetration compared to those who had a partner and were not cohabiting and those who were currently married. Perpetration of physical IPV was significantly higher among men residing in urban and rural formal areas than those in rural informal areas.

3.5.2. Prevalence of lifetime sexual IPV

Lifetime sexual IPV among ever-partnered women was 7.9% [95% CI: 6.5-9.4], which translates to an estimated 1 131 293 ever-partnered women who experienced sexual IPV in their lifetime (Appendix H). Lifetime sexual IPV victimisation varied significantly by current relationship status, race, and locality (Table 9). A significantly higher proportion of ever-partnered women who were not currently in a relationship reported experiencing lifetime sexual IPV than those who were currently married. A higher proportion of Black African women reported having ever experienced lifetime sexual IPV, than women of other race groups. A significantly higher proportion of women in urban areas reported having experienced lifetime sexual IPV than those in rural formal areas.

Among ever-partnered men, self-reported lifetime perpetration of sexual IPV was 7.5% [95% CI: 6.2-9.2], which translates to an estimated 917 395 ever-partnered men who perpetrated sexual IPV in their lifetime (Appendix I). It varied significantly by age, current relationship status, and education attainment level (Table 10). Significantly more men aged 18–24 years, 25–34 years and 35–49 years reported having ever perpetrated sexual IPV in their lifetime, compared to men aged 50 years and older. A significantly higher proportion of men who had secondary school education as their highest education attainment level had perpetrated lifetime sexual IPV compared to men who had completed only primary school education.

3.5.3. Lifetime physical and/or sexual IPV

Overall, 23.9% [95% CI: 21.7-26.3] of ever-partnered women reported experiencing physical and/or sexual IPV during their lifetime (Table 9), which translates to an estimated 3 448 669 ever-partnered women who experienced lifetime physical and/or sexual IPV (Appendix H). This varied significantly by race and current relationship status. Lifetime physical and/or sexual IPV was significantly higher among Black African women ever-partnered women than those of other race groups. Ever-partnered women who were cohabiting with a partner and not married reported significantly higher proportions of lifetime physical and/or sexual IPV than women who were currently married.

Among ever-partnered men, 20.5% [95% CI: 18.5-22.6] self-reported perpetrating physical and/or sexual IPV during their lifetime (Table 10), which translates to an estimated 3 192 790 ever-partnered men who have physically and/or sexually violated a woman in their lifetime (Appendix I). The perpetration of lifetime physical and/or sexual IPV varied significantly by age, current relationship status, and locality. The proportions of men who reported perpetrating physical and/or sexual IPV in their lifetime ranged from 17.1% among men aged 50 years and older to 23.7% among men aged 25–34 years. A higher proportion of men who were not in a relationship reported perpetrating physical and/or sexual IPV during their lifetime. Significantly higher proportions of ever-partnered men in urban areas reported having perpetrated lifetime physical and/or sexual IPV than those in rural informal areas.

Table 9: Percentage of ever-partnered women aged 18 and older who reported experiencing physical and/or sexual IPV in their lifetime, South Africa, 2022

	Ever experienced physical IPV[1]				Ever experienced sexual IPV[2]				Ever experienced physical and/or sexual IPV[3]			
	%	95% CI	N	p-value	%	95% CI	n	p-value	%	95% CI	n	p-value
Total	22.4	[20.1-24.7]	3 797		7.9	[6.5-9.4]	3 789		23.9	[21.7-26.3]	3 799	
Age group				0.252				0.579				0.167
18-24	25.0	[19.1-32.0]	221		7.7	[4.3-13.5]	222		26.2	[20.1-33.3]	222	
25-34	23.2	[18.5-28.7]	678		9.4	[6.2-13.9]	677		26.3	[21.5-31.7]	678	
35-49	24.0	[20.5-27.8]	1 177		7.8	[6.0-10.2]	1 175		25.0	[21.4-28.9]	1 178	
50+	19.7	[16.9-22.9]	1 721		7.9	[5.5-8.8]	1 715		20.9	[18.0-24.1]	1 721	
Race				0.021				0.007				0.007
Black African	24.1	[21.6-26.7]	2 745		8.9	[7.3-10.7]	2 738		26.0	[23.5-28.6]	2 746	
Other race	17.3	[13.0-22.6]	1 041		4.9	[3.2-7.3]	1 040		17.8	[13.5-23.1]	1 042	
Highest level of education				0.664				0.259				0.870
No formal schooling	22.1	[15.5-30.4]	207		3.7	[1.6-7.9]	205		22.3	[15.7-30.7]	207	
Primary school	24.1	[19.5-29.4]	625		6.4	[4.5-9.0]	623		24.8	[20.1-30.2]	625	
Secondary school	22.8	[20.1-25.8]	2 296		8.0	[6.2-10.2]	2 294		24.3	[21.5-27.3]	2 298	
Tertiary	20.4	[15.7-26.1]	663		9.2	[6.2-13.3]	661		22.8	[18.0-28.5]	663	
Employment status				0.254				0.085				0.189
Unemployed	22.0	[19.1-25.2]	2 095		6.9	[5.2-9.2]	2 091		23.3	[20.4-26.5]	2 097	
Employed	24.6	[21.3-28.2]	1 278		9.4	[7.4-11.8]	1 276		26.3	[23.0-29.9]	1 278	
Current relationship status				0.002				0.009				0.002
Currently married	18.5	[15.5-22.0]	1 865		5.9	[4.6-7.6]	1 859		19.9	[16.9-23.3]	1 866	
Cohabiting, not married	29.4	[23.6-35.8]	380		9.5	[5.7-15.4]	380		30.6	[24.9-37.1]	380	
Partner, not cohabiting	25.3	[20.8-30.5]	544		7.5	[5.0-11.2]	544		27.4	[22.8-32.6]	545	
No relationship	24.8	[21.0-29.1]	997		11.1	[8.4-14.5]	996		26.5	[22.6-30.9]	997	
Locality type				0.724				0.045				0.581
Urban	22.7	[20.0-25.6]	2 757		8.5	[6.8-10.6]	2 752		24.4	[21.7-27.3]	2 759	
Rural informal (tribal areas)	21.5	[17.5-26.2]	723		6.3	[4.7-8.3]	721		22.8	[18.7-27.5]	723	
Rural formal (farms)	20.5	[15.4-26.9]	317		3.8	[2.2-6.7]	316		21.1	[15.9-27.5]	317	

1. Any one or more of the following: a) slapped you or thrown something at you that could hurt you; b) pushed you or shoved you or pulled your hair; c) hit you with his fist or with something else that could hurt you; d) kicked you; dragged you or beat you up; e) choked or burnt you on purpose; f) threatened with or actually used a gun; knife or other weapon against you;
2. Any one or more of the following: a) force you to have sexual intercourse when you did not want to; for example by threatening you or holding you down; b) ever have sexual intercourse you did not want to because you were afraid of what your partner might do if you refused; c) force you to do anything else sexual that you did not want or that you found degrading or humiliating;
3. 1 and/or 2.

Table 10: Percentage of ever-partnered men aged 18 years and older who self-reported perpetrating physical and/or sexual IPV in their lifetime, South Africa, 2022

	Ever perpetrated physical IPV[1]				Ever perpetrated sexual IPV[2]				Perpetrated physical and/or sexual IPV[3]			
	%	95% CI	N	p-value	%	95% CI	n	p-value	%	95% CI	n	p-value
Total	16.7	[14.8-18.7]	3 333		7.5	[6.2-9.2]	2 790		20.5	[18.5-22.6]	3 468	
Age group				0.004				0.001				0.049
18-24	9.2	[6.4-13.1]	397		11.1	[7.7-15.9]	353		17.2	[13.1-22.3]	414	
25-34	20.5	[16.4-25.3]	776		8.8	[6.3-12.1]	617		23.7	[19.6-28.4]	807	
35-49	17.6	[14.6-21.1]	1 093		9.0	[6.4-12.6]	859		22.0	[18.6-25.9]	1 134	
50+	15.6	[12.3-19.5]	1 065		3.2	[1.8-5.5]	959		17.1	[13.1-22.3]	1 111	
Race				0.429				0.059				0.588
Black African	16.2	[14.3-18.4]	2 708		8.3	[6.7-10.3]	2 229		20.2	[18.0-22.5]	2 823	
Other race	18.5	[13.7-24.6]	624		5.0	[3.1-8.1]	560		21.8	[16.7-28.0]	643	
Current relationship status				0.001				0.043				0.028
Currently married	15.4	[12.6-18.6]	1 331		5.6	[3.7-8.4]	1 175		18.5	[15.4-22.1]	1 384	
Cohabiting, not married	24.5	[19.5-30.2]	575		6.7	[4.3-10.3]	464		26.2	[21.3-31.8]	594	
Partner, not cohabiting	13.9	[11.3-17.0]	1 248		10.0	[7.9-12.7]	988		19.2	[16.3-22.5]	1 301	
No relationship	26.0	[15.8-39.6]	179		6.9	[3.2-14.5]	163		28.5	[18.6-41.0]	189	
Highest level of education				0.512				0.018				0.578
No formal schooling	9.3	[4.5-18.3]	81		6.6	[2.0-19.2]	75		13.4	[6.7-24.8]	86	
Primary school	18.0	[13.4-23.8]	529		2.6	[1.3-5.4]	476		18.9	[14.4-24.5]	560	
Secondary school	16.3	[14.0-18.8]	2 140		8.8	[7.0-11.0]	1 772		20.8	[18.3-23.5]	2 217	
Tertiary	18.2	[13.6-24.1]	516		7.5	[4.9-11.2]	416		22.0	[17.2-27.7]	537	
Employment status				0.048				0.860				0.209
Unemployed	14.4	[11.8-17.5]	1 172		7.7	[5.8-10.2]	1 009		19.0	[16.3-22.2]	1 225	
Employed	18.3	[15.8-21.0]	2 140		7.5	[5.8-9.6]	1 759		21.6	[19.0-24.5]	2 220	
Locality type				0.001				0.415				0.006
Urban	18.4	[16.0-21.1]	2 056		7.8	[6.1-10.0]	1 682		22.3	[19.7-25.1]	2 137	
Rural informal (tribal areas)	11.6	[8.9-15.0]	690		7.6	[5.1-11.0]	594		15.9	[12.8-19.5]	729	
Rural formal (farms)	19.7	[15.3-25.1]	587		4.5	[2.7-7.6]	514		21.4	[16.6-27.2]	602	

1. Ever did any one or more of the following: a) Slapped a partner or thrown something at her that could hurt her, b) pushed or shoved a partner, c) hit a partner with a fist or with something else that could hurt her, d) kicked, dragged, beaten, choked or burned a partner, e) threatened to use or actually used a gun, knife or other weapon against a partner;
2. Ever did any one or more of the following: a) coerced/forced or/and manipulated your current or previous wife or girlfriend to have sex with you when she did not want to, b) had sex with your current or previous wife or girlfriend when you knew she didn't want it but you believed she should agree because she was your wife/partner, c) coerced/forced or manipulated your current or previous wife or girlfriend to watch pornography when she didn't want to, d) coerced/forced or manipulated your current or previous wife or girlfriend to do something sexual that she did not want to do;
3. 1 and/or 2.

3.6. Individual drivers for victimisation and perpetration of IPV

Lifetime experiences of victimisation and perpetration of physical and/or sexual IPV by various factors are presented in three categories for ever-partnered women in Table 11 and for ever-partnered men in Table 12.

3.6.1. Drivers for lifetime physical IPV victimisation among women

Experiencing physical IPV was significantly higher among ever-partnered women who had had more than one sexual partner in their lifetime compared with women who had had only one partner. Furthermore, the proportion of women who were victims of physical IPV was significantly higher among women who currently consumed alcohol once or twice a week and significantly higher among women who had ever used drugs, compared to those who had never used alcohol or drugs respectively. Reporting of physical IPV was significantly higher among ever-partnered women who had current mild, moderate or severe anxiety than those with minimal anxiety, and was significantly higher for those with current minimal, mild, moderate or severe depression than those with no depressive symptoms. The experience of physical IPV was significantly higher among ever-partnered women who had a history of suicidal ideation, had reported childhood experiences of physical, sexual and/or emotional abuse, and had a history of their mother experiencing abuse from a partner when they were a child than for women who did not report these. Furthermore, ever-partnered women who had low and moderate equitable attitudes and perceived norms related to gender relations, and had agreed to statements on gendered power relations, reported significantly higher proportions of physical IPV than those who had high equitable attitudes and perceived norms and those who disagreed with statements about gendered power relations respectively. Women who sometimes or often quarrelled with their current or most recent partner also reported significantly higher proportions of physical IPV than those who never quarrelled with their partner (Table 11).

3.6.2. Drivers for lifetime perpetration of physical IPV among men

The proportion of men who perpetrated physical IPV was significantly higher among ever-partnered men who had engaged in transactional sex than those who had not. It was also significantly higher for men who had had four or more sexual partners in their lifetime compared to men who had had one partner. Men's perpetration of physical IPV was significantly higher among current hazardous alcohol drinkers compared to men who did not engage in hazardous alcohol intake (Table 12).

In terms of mental health, the proportion of men who perpetrated physical IPV was significantly higher among men who were at risk for clinical depression than those who were not, and was significantly higher among men who had lower scores on the current life satisfaction scale compared with men who had higher/neutral scores. Furthermore, significantly higher proportions of ever-partnered men who had a history of suicidal ideation, and/or who had attempted suicide in their lifetime, reported having perpetrated physical IPV compared to their counterparts (Table 12).

Regarding childhood trauma, significantly higher proportions of ever-partnered men who had high or medium scores on the childhood trauma scale reported having perpetrated physical IPV than those with low childhood trauma scores. Significantly higher proportions of ever-partnered men who had bullied, harassed or teased others, or were themselves bullied while growing up, reported having perpetrated physical IPV than those who did not bully others and were not bullied (Table 12).

Significantly higher proportions of ever-partnered men who had high inequitable gender-related perceived norms reported having perpetrated physical IPV compared to those with more equitable gender-related norms. Similarly, significantly higher proportions of ever-partnered men who had high inequitable attitudes about gendered power relations reported having perpetrated physical IPV compared to their counterparts with low inequitable attitudes (Table 12). Significantly higher proportions of ever-partnered men who came from households that went without food at times due to a lack of money reported having perpetrated physical IPV than those who did not experience food insecurity (Table 12).

3.6.3. Drivers for lifetime sexual IPV victimisation among women

Reports of sexual IPV was significantly higher among women who had had more than one sexual partner in their lifetime than those who had had one partner. Experiencing sexual IPV was significantly higher among women who reported drinking alcohol every day and who had ever used drugs than those who never used these substances. It was also significantly higher among those with mild, moderate or severe anxiety than those with minimal anxiety. Ever-partnered women who had current mild, moderate or severe depression and who had a history of suicidal ideation also reported significantly higher proportions of sexual IPV experiences than those with no depression, and who never had suicidal ideation respectively. Reported sexual IPV was significantly higher among women who reported a history of physical, sexual and emotional abuse before age 15, reported that their mother experienced physical abuse from a partner when they were a child, and who often quarrelled with their current or most recent partner than those who did not report these (Table 11).

3.6.4. Drivers for lifetime perpetration of sexual IPV among men

The proportion of ever-partnered men who perpetrated sexual IPV was significantly higher among ever-partnered men who had engaged in transactional sex compared to men who had not. Men's perpetration of sexual IPV was significantly higher among current hazardous alcohol drinkers and men who engaged in drug use in the past 12 months compared to their counterparts who did not use these substances (Table 12).

The proportion of men who perpetrated sexual IPV was significantly higher for men who were at risk for clinical depression than for men who were not at risk for clinical depression. Furthermore, higher proportions ever-partnered men who had attempted suicide in their lifetime reported having perpetrated sexual IPV compared to their counterparts who had not attempted suicide (Table 12). The perpetration of sexual IPV was significantly higher among men who showed lower empathic concern than men with higher empathic concern.

With regards to childhood trauma, it was noted that significantly higher proportions of ever-partnered men who had high scores on the childhood trauma scale reported perpetrating sexual IPV compared to their counterparts with low childhood trauma scores. Significantly higher proportions of ever-partnered men with a history of bullying others, teasing or harassing others while growing up reported perpetrating sexual IPV than those who had not (Table 12).

3.6.5. Drivers for lifetime physical and/or sexual IPV victimisation among women

Reports of physical and/or sexual IPV were significantly higher among ever-partnered women who had had more than one sexual partner in their lifetime than those who had had only one partner (Table 11). It was also significantly higher among women who currently consumed alcohol once or twice a week or every day, and had a history of drug use, compared to those who never used these substances.

Ever-partnered women who had current mild, moderate or severe anxiety, reported current minimal, mild, moderate or severe depression, and had a history of suicidal ideation had significantly higher proportions of reported physical and/or sexual IPV by a partner than those who had minimal anxiety, no depression and no suicidal ideation respectively (Table 11).

Similarly, ever-partnered women who had reported childhood experiences of physical, sexual and emotional abuse before age 15 and women who reported that their mother experienced physical abuse by a partner when they were a child, had significantly higher proportions of reported physical and/or sexual IPV compared to women who did not report childhood experiences of abuse and did not report that their mother experienced physical abuse (Table 11).

Furthermore, ever-partnered women who had low and moderate equitable attitudes and perceived norms related to gender relations, those who agreed to statements on power relations and reported sometimes or often quarrelling with their partner also had significantly higher proportions of reported physical and/or sexual IPV compared to women who reported high equitable attitudes and perceived norms, those who disagreed with statements on power relations and those who reported never quarrelling with their partner (Table 11).

3.6.6. Drivers for lifetime perpetration of physical and/or sexual IPV among men

The proportion of men who perpetrated physical and/or sexual IPV was significantly higher among ever-partnered men who had ever engaged in transactional sex than their counterparts who had not (Table 12).

The proportion of men who perpetrated physical and/or sexual IPV was highest among ever-partnered men who had had four or more sexual partners in their lifetime than men who had had only one partner (Table 12). Regarding substance use, men's perpetration of physical and/or sexual IPV was significantly higher among current hazardous alcohol drinkers than their counterparts who did not engage in hazardous alcohol intake (Table 12).

With regards to men's mental health, the proportion of men who perpetrated physical and/or sexual IPV was significantly higher among men who were at risk for clinical depression and had lower scores on the current life satisfaction scale than men who had higher/neutral scores (Table 12). Furthermore, significantly higher proportions of ever-partnered men who had a history of suicidal ideation and/or had attempted suicide in their lifetime reported perpetrating physical and/or sexual IPV compared to their counterparts who had not.

With regards to men's experiences of childhood trauma, significantly higher proportions of ever-partnered men who had high scores on the childhood trauma scale reported having perpetrated physical and/or sexual IPV compared to their counterparts with medium or low childhood trauma scores (Table 12). Significantly more ever-partnered men who had bullied, harassed or teased others, or were themselves bullied while growing up, reported having perpetrated physical and/or sexual IPV than those who had not.

Significantly higher proportions of ever-partnered men who had high inequitable gender-related attitudes and perceived norms about gender relations reported perpetrating physical and/or sexual IPV compared to those with low inequitable gender-related attitudes and norms (Table 12). Furthermore, significantly higher proportions of ever-partnered men who had high inequitable attitudes towards gendered power relations reported having perpetrated physical and/or sexual IPV compared to their counterparts with low or medium inequitable attitudes.

Significantly more ever-partnered men from households that had food insecurity or went without food at times due to a lack of money reported having perpetrated physical and/or sexual IPV than those whose households did not go without food (Table 12).

Table 11: Percentage of ever-partnered women aged 18 years and older who self-reported experiencing physical and/or sexual IPV in their lifetime by socio-behavioural, psychological and childhood risk factors, South Africa, 2022

	Ever experienced physical violence[1]				Ever experienced sexual violence[2]				Ever experienced physical and/or sexual violence[3]			
	%	95% CI	n	p-value	%	95% CI	n	p-value	%	95% CI	n	p-value
SEXUAL BEHAVIOUR												
Number of lifetime sexual partners				<0.001				<0.001				<0.001
1 partner	12.4	[10.0-15.2]	1 310		4.1	[2.9-5.7]	1307		13.0	[10.6-15.8]	1310	
2–3 partners	22.0	[18.6-25.9]	1 408		8.0	[6.0-10.5]	1407		23.4	[19.9-27.3]	1410	
4+ partners	34.0	[29.8-38.6]	994		12.0	[9.1-15.7]	991		36.9	[32.6-41.4]	994	
Current condom use				0.032				0.027				0.008
Yes	27.2	[22.1-33.1]	531		10.9	[7.4-15.9]	531		30.0	[24.8-35.7]	531	
No	21.3	[19.0-23.8]	3 266		7.2	[6.1-8.5]	3258		22.6	[20.3-25.1]	3268	
SUBSTANCE USE												
Current frequency of alcohol intake				<0.001				0.055				<0.001
Never	19.1	[16.7-21.7]	2 574		7.0	[5.7-8.6]	2 567		20.4	[17.9-23.1]	2 574	
Less than once a month	26.1	[20.4-32.6]	437		9.4	[6.2-13.9]	437		28.6	[22.6-35.4]	437	
1–3 times a month	24.7	[19.3-31.1]	405		8.2	[4.8-13.8]	404		26.4	[20.8-32.9]	406	
Once or twice a week	33.6	[25.3-43.1]	307		8.7	[5.0-14.6]	307		35.1	[26.7-44.6]	307	
Every day	32.9	[18.1-52.2]	71		22.6	[10.7-41.5]	71		37.9	[24.7-53.2]	72	
Drug use during one's lifetime				<0.001				<0.001				<0.001
Yes	45.7	[33.3-58.6]	99		20.1	[11.2-33.4]	99		50.4	[37.7-63.1]	99	
No	21.4	[19.2-23.8]	3 683		7.4	[6.2-8.9]	3 675		22.9	[20.7-25.3]	3 685	
MENTAL HEALTH												
Generalised anxiety disorder				<0.001				<0.001				<0.001
Minimal anxiety	18.4	[16.1-21.0]	2 461		5.3	[4.2-6.6]	2 455		19.7	[17.4-22.3]	2 463	
Mild anxiety	30.1	[26.0-34.4]	882		11.3	[8.6-14.9]	881		31.7	[27.5-36.2]	882	
Moderate anxiety	33.7	[25.3-43.3]	196		14.3	[7.7-25.0]	196		37.0	[28.4-46.5]	196	
Severe anxiety	33.6	[21.2-48.8]	123		23.6	[12.2-40.7]	123		36.8	[23.9-51.9]	123	
Depression (Patient Health Questionnaire-9 -PHQ-9)				<0.001				<0.001				<0.001
Not at all	12.2	[9.7-15.2]	1 103		3.6	[2.3-5.5]	1 102		13.2	[10.5-16.3]	1 105	
Minimal depression	23.0	[19.1-27.3]	1 174		5.9	[4.5-7.8]	1 169		24.1	[20.2-28.4]	1 174	
Mild depression	26.5	[22.9-30.4]	904		11.3	[8.7-14.6]	904		28.7	[24.9-32.9]	904	
Moderate depression	37.3	[29.1-46.3]	243		15.6	[9.3-24.8]	243		39.3	[31.1-48.2]	243	
Moderate/severe depression	22.2	[11.7-38.1]	101		10.9	[4.7-23.4]	100		25.2	[14.0-41.1]	101	
Severe depression	44.8	[25.5-65.7]	68		27.9	[10.8-55.2]	68		45.9	[26.6-66.5]	68	
Ever had suicidal ideation				<0.001				<0.001				<0.001
Yes	49.2	[40.8-57.6]	365		21.4	[14.2-30.9]	365		52.4	[44.5-60.2]	365	
No	19.1	[17.1-21.3]	3 421		6.2	[5.2-7.4]	3 413		20.5	[18.4-22.7]	3 423	

	Ever experienced physical violence[1]				Ever experienced sexual violence[2]				Ever experienced physical and/or sexual violence[3]			
	%	95% CI	n	p-value	%	95% CI	n	p-value	%	95% CI	n	p-value
CHILDHOOD EXPERIENCES												
History of childhood physical abuse				<0.001				<0.001				<0.001
Yes	28.7	[25.6-32.0]	2 059		9.9	[7.8-12.4]	2 056		30.4	[27.2-33.7]	2 059	
No	13.2	[10.8-16.1]	1 459		5.2	[3.8-7.1]	1 457		14.8	[12.3-17.7]	1 461	
History of childhood sexual abuse				<0.001				<0.001				<0.001
Yes	47.5	[32.8-62.7]	120		23.6	[12.6-39.7]	119		56.2	[41.7-69.7]	120	
No	21.3	[19.2-23.6]	3 659		7.2	[6.0-8.5]	3 652		22.5	[20.4-24.8]	3 661	
History of childhood emotional abuse				<0.001				<0.001				<0.001
Yes	38.2	[31.2-45.7]	366		17.2	[11.9-24.3]	364		40.1	[33.0-47.5]	366	
No	20.5	[18.2-22.9]	3 332		6.6	[5.5-7.8]	3 328		22.1	[19.8-24.5]	3 334	
Reported that mother was physically abused by a partner				<0.001				<0.001				<0.001
Yes	32.4	[27.5-37.6]	789		12.9	[9.6-17.2]	789		34.3	[29.4-39.6]	789	
No	18.6	[16.3-21.1]	2 553		6.0	[4.9-7.5]	2 547		20.1	[17.7-22.6]	2 555	
NORMS AND ATTITUDES												
Gender relations				<0.001				0.555				<0.001
Low equity	25.9	[22.5-29.7]	1 320		8.0	[6.1-10.3]	1 319		27.6	[24.2-31.3]	1 320	
Medium equity	24.6	[20.8-28.9]	1 267		8.8	[6.5-11.8]	1 263		26.1	[22.3-30.4]	1 267	
High equity	16.6	[13.5-20.2]	1 093		7.1	[5.1-9.7]	1 091		18.3	[15.1-22.0]	1 095	
Attitudes towards gendered power relations				<0.001				0.338				<0.001
Agree	49.4	[33.8-65.1]	62		11.9	[5.5-23.9]	62		49.4	[33.8-65.1]	62	
Somewhat agree	40.9	[21.7-63.3]	33		3.4	[0.6-17.0]	33		40.9	[21.7-63.3]	33	
Disagree	21.8	[19.6-24.2]	3 701		7.8	[6.5-9.4]	3 693		23.4	[21.1-25.8]	3 703	
OTHER												
Food insecurity				0.725				0.188				0.667
Yes	23.0	[20.0-26.3]	1 863		8.9	[7.1-11.0]	1 858		24.7	[21.6-28.0]	1 864	
No	22.2	[19.3-25.5]	1 790		7.2	[5.6-9.4]	1 788		23.7	[20.7-27.0]	1 791	
Quarrel with partner				<0.001				<0.001				<0.001
Rarely	13.1	[10.8-15.9]	1 880		4.3	[2.8-6.4]	1 874		13.8	[11.4-16.6]	1 881	
Sometimes	25.3	[21.7-29.3]	1 312		7.7	[5.8-10.2]	1 312		27.4	[23.7-31.4]	1 313	
Often	45.8	[39.1-52.7]	486		22.6	[17.3-28.9]	486		48.6	[41.8-55.5]	486	

1. Any one or more of the following: a) slapped you or thrown something at you that could hurt you; b) pushed you or shoved you or pulled your hair; c) hit you with his fist or with something else that could hurt you; d) kicked you; dragged you or beat you up; e) choked or burnt you on purpose; f) threatened with or actually used a gun; knife or other weapon against you;
2. Any one or more of the following: a) force you to have sexual intercourse when you did not want to; for example by threatening you or holding you down; b) ever have sexual intercourse you did not want to because you were afraid of what your partner might do if you refused; c) force you to do anything else sexual that you did not want or that you found degrading or humiliating;
3. 1 and/or 2.

Table 12: Percentage of ever-partnered men aged 18 years and older who self-reported perpetrating physical and/or sexual IPV in their lifetime, by socio-behavioural, psychological and childhood risk factors, South Africa, 2022

	Ever perpetrated physical violence[1]				Ever perpetrated sexual violence[2]				Perpetrated physical and/ or sexual violence[3]			
	%	[95% CI]	n	p-value	%	[95% CI]	n	p-value	%	[95% CI]	n	p-value
SEXUAL BEHAVIOUR												
Partner's age (current/most recent partner)				0.727				0.342				0.569
Partner is >5 years older	20.8	[10.3-37.4]	56		14.7	[5.5-33.8]	49		26.6	[14.8-43.0]	58	
Partner is >5 years younger	15.9	[13.2-19.0]	1 477		7.2	[5.2-9.9]	1 242		19.8	[16.9-23.0]	1 527	
Partner within 5 years older or younger	16.9	[14.2-20.0]	1 552		8.3	[6.5-10.5]	1 288		21.2	[18.3-24.3]	1 620	
Transactional sex				<0.001				<0.001				<0.001
Ever engaged in transactional sex	22.3	[18.7-26.3]	1 138		17.8	[13.8-22.6]	733		28.6	[24.7-32.8]	1 175	
Never engaged in transactional sex	13.6	[11.5-16.1]	1 924		4.2	[3.1-5.6]	2 004		16.3	[14.1-18.8]	2 020	
Number of lifetime sexual partners				0.037				0.224				0.018
1 partner	9.5	[6.0-14.7]	335		5.6	[2.9-10.4]	319		12.4	[8.3-18.3]	350	
2–3 partners	17.1	[12.2-23.5]	619		6.0	[3.8-9.6]	582		20.5	[15.5-26.6]	644	
4+ partners	18.3	[16.0-20.8]	2 272		8.5	[6.8-10.5]	1 862		22.5	[20.1-25.1]	2 367	
SUBSTANCE USE												
Hazardous drinking or active alcohol use disorders (AUDIT-C)				<0.001				<0.001				<0.001
No hazardous drinking	12.6	[10.2-15.4]	1 630		4.7	[3.5-6.5]	1 503		15.3	[12.8-18.1]	1 698	
Hazardous drinking	20.8	[17.9-24.0]	1 588		10.8	[8.5-13.7]	1 244		25.9	[22.8-29.2]	1 652	
Drug use (past 12 months)				0.111				0.001				0.017
Do not use drugs	16.6	[14.5-18.9]	2 929		6.9	[5.5-8.4]	2 507		20.2	[18.1-22.6]	3 039	
Use drugs	21.7	[16.0-28.8]	231		16.3	[10.1-25.3]	180		28.9	[22.0-36.9]	245	
MENTAL HEALTH												
Centre for Epidemiologic Studies Depression Scale (CES-D)				<0.001				<0.001				<0.001
Not at risk for clinical depression	14.2	[12.1-16.6]	2 281		5.3	[4.1-6.8]	1 931		16.9	[14.7-19.3]	2359	
At risk for clinical depression	23.9	[19.9-28.4]	763		13.6	[9.7-18.9]	609		30.3	[25.9-35.0]	798	
Ever suicidal ideation				<0.001				0.015				<0.001
No	15.4	[13.5-17.5]	2 931		6.9	[5.5-8.6]	2 493		19.3	[17.2-21.5]	3 047	
Yes	25.9	[20.4-32.3]	369		12.6	[8.2-19.0]	279		29.5	[23.8-36.0]	385	
Ever attempted suicide				0.001				0.010				0.001
No	16.0	[14.2-18.0]	3 163		7.1	[5.7-8.8]	2 660		19.8	[17.8-21.9]	3 285	
Yes	31.1	[21.2-43.0]	137		15.9	[8.9-26.8]	112		35.8	[25.8-47.1]	147	
Satisfaction with Life				<0.001				0.994				0.003
Higher/neutral	14.1	[12.1-16.4]	2 051		7.5	[5.8-9.6]	1 740		18.1	[15.7-20.7]	2 125	
Lower	21.0	[17.6-24.8]	1 233		7.4	[5.6-9.9]	1 010		24.5	[21.0-28.3]	1 289	
Empathic Concern				0.438				<0.001				0.207
Lower empathic concern	14.6	[10.3-20.3]	332		18.0	[11.5-26.8]	276		24.4	[18.1-32.2]	340	
Higher empathic concern	16.8	[14.8-19.0]	2 939		6.3	[5.1-7.8]	2 471		19.9	[17.8-22.2]	3 064	
CHILDHOOD TRAUMA												
Childhood trauma scale				<0.001				<0.001				<0.001
Low (0–3)	9.5	[7.7-11.6]	1 447		4.4	[2.9-6.6]	1 243		12.1	[10.0-14.5]	1 500	
Medium (4–6)	18.7	[14.8-23.2]	903		7.2	[4.9-10.5]	746		22.1	[18.1-26.7]	936	
High (7+)	30.7	[26.0-35.8]	836		15.4	[12.1-19.4]	682		37.3	[32.5-42.3]	878	
Bullied, teased or harassed				<0.001				0.333				<0.001
No	14.1	[12.2-16.2]	2 168		7.0	[5.4-9.0]	1 850		17.6	[15.5-19.9]	2 268	
Yes	21.9	[18.4-25.9]	1 079		8.5	[6.2-11.4]	872		26.3	[22.6-30.4]	1 110	
Bullied, teased, or harassed others				<0.001				<0.001				<0.001
No	14.3	[12.6-16.2]	2 577		6.0	[4.7-7.6]	2 184		17.3	[15.5-19.3]	2 680	
Yes	28.3	[22.6-34.9]	663		14.3	[10.4-19.4]	528		35.0	[29.1-41.5]	690	
GENDER-RELATED NORMS AND ATTITUDES												
Gender-related norms (higher = more inequitable)				<0.001				0.161				<0.001
Low	12.6	[10.0-15.7]	1 275		6.5	[4.7-9.0]	1 079		16.4	[13.5-19.6]	1 325	
Medium	17.8	[14.9-21.2]	1 256		7.2	[5.2-9.7]	1 049		21.5	[18.4-25.1]	1 306	
High	24.1	[19.6-29.2]	707		10.1	[7.2-14.0]	577		27.7	[23.1-32.9]	731	
Attitudes towards gendered power relations (higher = more inequitable)				<0.001				0.012				<0.001
Low	14.7	[12.0-18.0]	1 311		6.3	[4.7-8.6]	1 118		18.0	[15.1-21.3]	1 369	
Medium	13.9	[10.9-17.6]	827		6.1	[4.0-9.1]	700		17.5	[14.3-21.3]	868	
High	23.2	[19.5-27.3]	1 017		11.0	[8.0-14.8]	827		28.0	[24.1-32.4]	1 045	
OTHER												
Food insecurity				<0.001				0.068				0.001
No	14.5	[12.5-16.9]	2 213		6.6	[5.1-8.6]			18.2	[16.0-20.7]	2293	
Yes	22.3	[18.4-26.7]	1 019		9.6	[7.0-12.9]			26.4	[22.3-30.9]	1072	

1. Ever did any one or more of the following: a) slapped a partner or thrown something at her that could hurt her, b) pushed or shoved a partner, c) hit a partner with a fist or with something else that could hurt her, d) kicked, dragged, beaten, choked or burned a partner, e) threatened to use or actually used a gun, knife or other weapon against a partner;
2. Ever did any one or more of the following: a) coerced/forced or/and manipulated your current or previous wife or girlfriend to have sex with you when she did not want to, b) had sex with your current or previous wife or girlfriend when you knew she didn't want it but you believed she should agree because she was your wife/partner, c) coerced/forced or manipulated your current or previous wife or girlfriend to watch pornography when she didn't want to, d) coerced/forced or manipulated your current or previous wife or girlfriend to do something sexual that she did not want to do;
3. 1 and/or 2.

3.7. Prevalence of recent physical and sexual IPV

In addition to measuring lifetime experiences of physical and sexual IPV, we also measured recent experiences. These are defined as experiences of victimisation or perpetration of violence in the previous 12 months.

3.7.1. Prevalence of recent physical IPV victimisation and perpetration

Overall, 5.2% [95% CI: 4.2-6.3] of ever-partnered women reported experiencing physical IPV during the past 12 months (Table 13). This translates to an estimated 747 188 ever-partnered women having recently experienced physical IPV (Appendix H). Recent experiences of physical IPV victimisation varied significantly by age, race, current relationship status, and highest education level. Significantly more ever-partnered women aged 18–24 (10.6%), 25–34 (7.3%) and 35–49 (6.6%) reported experiencing recent physical IPV than those aged 50 years and older (1.2%). Black African women reported significantly more recent physical IPV than women of other race groups. Women who were cohabiting with a partner and those in a relationship but not cohabiting reported significantly more recent physical IPV victimisation than those who were currently married or were not currently in a relationship. Women who had a secondary school education also reported significantly higher proportion of recent physical IPV victimisation than women who had no formal schooling.

Overall, 2.4% [95% CI: 1.7-3.5] of ever-partnered men reported perpetrating physical IPV during the past 12 months (Table 14). This translates to an estimated 366 030 ever-partnered men who recently perpetrated physical IPV (Appendix I). Recent physical IPV perpetration varied significantly by age and current relationship status. A significantly higher proportion of men aged 25–34 reported recent physical IPV perpetration than their counterparts aged 50 years and older. Men who were cohabiting and not married reported a significantly higher proportion of recent physical IPV perpetration than men who were currently married.

3.7.2. Prevalence of recent sexual IPV victimisation and perpetration

The proportion of ever-partnered women who reported experiencing recent sexual IPV was 2.5% [95% CI: 1.9-3.2], which translates to an estimated 354 196 ever-partnered women having recently experienced sexual IPV (Table 13 and Appendix H). Recent experiences of sexual IPV prevalence varied significantly by age, race, highest level of education, and current relationship status (Table 13). Recent experiences of sexual IPV victimisation were significantly higher among ever-partnered women aged 35-49 years (3.1%) than those aged 50 years and older (1.1%).

The proportion of ever-partnered men who reported perpetrating recent sexual IPV was 2.3% [95% CI: 1.7-3.2], which translates to an estimated 284 311 ever-partnered men having recently perpetrated sexual IPV (Appendix I). Prevalence varied significantly by age, current relationship status, and highest education level (Table 14). It was significantly higher among men aged 18–24, 25–34 and 35–49 years compared to their counterparts aged 50 years and older. Men who currently had a partner and were not cohabiting and men who were cohabiting but not married reported significantly higher proportions of recent sexual IPV perpetration than men who were currently married. Recent sexual IPV perpetration was significantly higher among men whose highest education levels were secondary school or tertiary than men with only primary school education.

3.7.3. Prevalence of recent physical and/or sexual IPV victimisation and perpetration

Overall, 6.4% [95% CI: 5.4-7.7] of ever-partnered women reported recent physical and/or sexual IPV (Table 13), which translates to an estimated 925 261 ever-partnered women having recently experienced physical and/or sexual IPV (Appendix H). Prevalence varied significantly by age, race, highest level of education, and current relationship status. Significantly more ever-partnered women aged 18–24 (12.2%), 25–34 (9.0%) and 35–49 (7.8%) reported recent experiences of physical and/or sexual IPV than those aged 50 years and older. Significantly higher proportions of Black African women reported recent experiences of physical and/or sexual IPV than women of other race groups. Women with secondary school education also reported significantly higher proportions of recent physical and/or sexual IPV compared to women with tertiary education or no formal schooling. Women who were cohabiting with a partner but not married and women who had a partner but were not cohabiting reported significantly higher proportions of physical and/or sexual IPV than women who were currently married or not currently in a relationship.

The percentage of ever-partnered men who reported recent perpetration of physical and/or sexual IPV was 4.0% [95% CI: 3.2-5.1], which translates to an estimated 627 939 ever-partnered men having recently perpetrated physical and/or sexual IPV (Table 14 and Appendix I). The prevalence of recent perpetration of physical and/or sexual IPV varied significantly by age, current relationship status, and highest education level (Table 14). Prevalence of perpetration was significantly higher among men aged 18–24 (4.8%), 25–34 (7.4%) and 35–49 (3.6%) years than among men aged 50 years and older (1.0%). Men who currently had a partner and were not cohabiting and men who were cohabiting but not married both reported significantly higher proportions of recent physical and/or sexual IPV perpetration than those who were currently married. Men whose highest education level was secondary school reported significantly higher proportions of recent physical and/or sexual IPV perpetration than men with primary school education as their highest education attainment level.

Table 13: Percentage of ever-partnered women aged 18 years and older who reported having experienced physical and/or sexual IPV in the past 12 months, South Africa, 2022

	Recently experienced physical violence[1]				Recently experienced sexual violence[2]				Recently experienced both physical and/or sexual violence[3]			
	%	95% CI	N	p-value	%	95% CI	n	p-value	%	95% CI	n	p-value
Total	5.2	[4.2-6.3]	3 797		2.5	[1.9-3.2]	3 789		6.4	[5.4-7.7]	3 799	
Age group				<0.001				0.024				<0.001
18–24	10.6	[6.4-17.1]	221		4.1	[1.8-9.0]	222		12.2	[7.6-19.2]	222	
25–34	7.3	[5.2-10.1]	678		3.1	[1.9-5.0]	677		9.0	[6.7-12.1]	678	
35–49	6.6	[4.9-8.9]	1 177		3.1	[2.1-4.6]	1 175		7.8	[5.9-10.2]	1 178	
50+	1.2	[0.8-1.9]	1 721		1.1	[0.6-2.0]	1 715		2.1	[1.4-3.1]	1 721	
Race				0.007				0.008				0.003
Black African	6.0	[4.8-7.4]	2 745		2.9	[2.2-3.8]	2 738		7.4	[6.1-8.9]	2 746	
Other race	2.8	[1.6-4.7]	1 041		1.0	[0.5-2.2]	1 040		3.5	[2.2-5.5]	1 042	
Highest level of education				0.009				0.048				0.003
No formal schooling	1.2	[0.3-4.0]	207		0.0		205		1.2	[0.3-4.0]	207	
Primary school	4.9	[2.8-8.7]	625		2.4	[1.3-4.2]	623		6.1	[3.5-10.4]	625	
Secondary school	6.4	[5.2-7.8]	2 296		3.1	[2.2-4.3]	2 294		7.9	[6.5-9.6]	2 298	
Tertiary	3.1	[1.8-5.4]	663		1.4	[0.8-2.6]	661		4.0	[2.5-6.3]	663	
Employment status				0.050				0.577				0.083
Unemployed	6.3	[4.8-8.1]	2 095		2.4	[1.6-3.6]	2 091		7.5	[5.9-9.5]	2 097	
Employed	4.2	[3.1-5.7]	1 278		2.8	[1.9-4.1]	1 276		5.4	[4.2-7.0]	1 278	
Current relationship status				<0.001				0.017				<0.001
Currently married	3.6	[2.4-5.3]	1 865		2.0	[1.3-3.0]	1 859		4.8	[3.4-6.6]	1 866	
Cohabiting, not married	12.2	[8.5-17.4]	380		5.1	[3.0-8.5]	380		13.3	[9.4-18.4]	380	
Partner, not cohabiting	10.0	[7.1-13.9]	544		3.6	[2.0-6.3]	544		11.8	[8.6-15.9]	545	
No relationship	2.0	[1.2-3.4]	997		1.5	[0.7-3.0]	996		2.9	[1.8-4.6]	997	
Locality type				0.457				0.895				0.522
Urban	5.4	[4.3-6.7]	2 757		2.4	[1.8-3.3]	2 752		6.6	[5.4-8.1]	2 759	
Rural informal (tribal areas)	4.4	[2.6-7.4]	723		2.5	[1.4-4.4]	721		5.6	[3.5-8.8]	723	
Rural formal (farms)	7.2	[4.3-11.7]	317		2.9	[1.5-5.5]	316		8.2	[5.2-12.8]	317	

1. Any one or more of the following: a) slapped you or thrown something at you that could hurt you; b) pushed you or shoved you or pulled your hair; c) hit you with his fist or with something else that could hurt you; d) kicked you; dragged you or beat you up; e) choked or burnt you on purpose; f) threatened with or actually used a gun; knife or other weapon against you;
2. Any one or more of the following: a) force you to have sexual intercourse when you did not want to; for example by threatening you or holding you down; b) ever have sexual intercourse you did not want to because you were afraid of what your partner might do if you refused; c) force you to do anything else sexual that you did not want or that you found degrading or humiliating;
3. 1 and/or 2.

Table 14: Percentage of ever-partnered men aged 18 and above who reported perpetrating physical and/or sexual IPV in the past 12 months, South Africa, 2022

	Perpetrated physical violence[1] in past 12 months				Perpetrated sexual violence[2] in past 12 months				Perpetrated physical and / or sexual violence[3] in past 12 months			
	%	95% CI	N	p-value	%	95% CI	n	p-value	%	95% CI	n	p-value
Total	2.4	[1.7-3.5]	3 330		2.3	[1.7-3.2]	2 788		4.0	[3.2-5.1]	3 465	
Age group				<0.001				0.001				<0.001
18–24	1.5	[0.7-3.1]	397		4.0	[2.1-7.6]	353		4.8	[2.9-7.9]	414	
25–34	5.2	[2.8-9.2]	775		3.5	[2.2-5.7]	617		7.4	[4.8-11.1]	806	
35–49	2.0	[1.4-3.1]	1 092		2.5	[1.5-4.3]	858		3.6	[2.5-5.0]	1 133	
50+	0.8	[0.3-1.9]	1 064		0.4	[0.1-1.0]	958		1.0	[0.5-2.1]	1 110	
Race				0.208				0.053				0.063
Black African	2.7	[1.8-4.0]	2 705		2.7	[2.0-3.8]	2 228		4.4	[3.4-5.7]	2 820	
Other race	1.6	[0.8-3.1]	624		1.0	[0.4-2.7]	559		2.5	[1.5-4.3]	643	
Current relationship status				0.006				0.001				<0.001
Currently married	0.9	[0.5-1.7]	1 329		0.7	[0.2-1.9]	1 174		1.5	[0.8-2.5]	1 382	
Cohabiting, not married	4.7	[2.7-7.8]	574		4.2	[2.2-7.7]	464		7.4	[4.9-11.0]	593	
Partner, not cohabiting	3.1	[1.7-5.6]	1 248		3.6	[2.5-5.3]	987		5.4	[3.7-7.7]	1 301	
No relationship	1.4	[0.3-7.0]	179		0.9	[0.1-6.3]	163		2.1	[0.6-7.2]	189	
Highest level of education				0.608				0.007				0.016
No formal schooling	2.9	[0.8-9.5]	81		0.0		75		2.7	[0.8-8.8]	86	
Primary school	1.5	[0.7-3.3]	529		0.1	[0.0-0.3]	476		1.4	[0.6-3.1]	560	
Secondary school	2.7	[1.7-4.3]	2 137		3.1	[2.2-4.4]	1 771		4.8	[3.6-6.4]	2 214	
Tertiary	2.4	[1.3-4.3]	516		1.7	[0.8-3.3]	415		3.6	[2.2-5.6]	537	
Employment status				0.461				0.803				0.855
Unemployed	2.2	[1.4-3.4]	1 172		2.5	[1.6-3.9]	1 008		4.0	[2.9-5.4]	1 225	
Employed	2.7	[1.7-4.1]	2 137		2.3	[1.5-3.5]	1 758		4.1	[3.0-5.6]	2 217	
Locality type				0.160				0.725				0.139
Urban	2.6	[1.6-4.1]	2 053		2.5	[1.7-3.7]	1 680		4.3	[3.2-5.9]	2 134	
Rural informal (tribal areas)	1.7	[0.9-3.2]	690		2.1	[1.2-3.6]	594		3.0	[1.9-4.5]	729	
Rural formal (farms)	4.4	[2.8-6.9]	587		1.8	[0.7-4.6]	514		5.7	[3.7-8.7]	602	

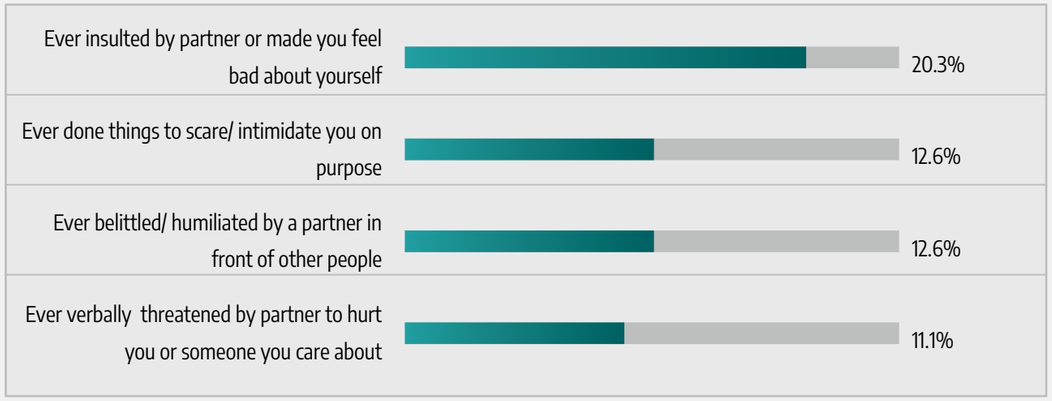
1. Any one or more of the following: a) Slapped a partner or thrown something at her that could hurt her, b) pushed or shoved a partner, c) hit a partner with a fist or with something else that could hurt her, d) kicked, dragged, beaten, choked or burned a partner, e) threatened to use or actually used a gun, knife or other weapon against a partner;
2. Any one or more of the following: a) coerced/forced or/and manipulated your current or previous wife or girlfriend to have sex with you when she did not want to, b) had sex with your current or previous wife or girlfriend when you knew she didn't want it but you believed she should agree because she was your wife/partner, c) coerced/forced or manipulated your current or previous wife or girlfriend to watch pornography when she didn't want to, d) coerced/forced or manipulated your current or previous wife or girlfriend to do something sexual that she did not want to do;
3. 1 and/or 2.

3.8. Prevalence of emotional abuse between intimate partners

3.8.1. Prevalence of lifetime emotional abuse

Emotional abuse among women was measured using four items that explored experiences of being insulted, scared or intimidated, belittled or humiliated, and verbally threatened by an intimate partner at any point in their lifetime. About one fifth (20.3%) of women reported that, in their lifetime, they had been insulted by a partner or deliberately made to feel bad about themselves, 12.6% had been deliberately scared or intimidated by a partner, 12.6% were belittled or humiliated by a partner in front of other people, and 11.1% reported that their partner had verbally threatened to hurt them or someone they care about (Figure 6).

Figure 6: Percentage of ever-partnered women aged 18 years and older who reported experiencing different emotionally abusive acts from their intimate partner(s) in their lifetime, South Africa, 2022



Overall, 25.1% [95% CI: 22.8-27.5] of ever-partnered women experienced one or more of these acts of emotional abuse in their lifetime. Experiences of lifetime emotional abuse varied significantly by age, current relationship status, level of education, employment status, and locality (Table 15). A significantly higher proportion of women aged 25–34 years reported experiencing one or more acts of emotional abuse during their lifetime compared to those aged 50 years and older. Experiences of lifetime emotional abuse were significantly higher among employed than unemployed women and among women with tertiary education than those with no formal schooling.

Further to the four items listed above, an additional item (deliberately hurting people or things a partner cared about) was used to measure perpetration of emotional abuse of an intimate partner by men at any point in their lifetime. Among ever-partnered men, 25.4% reported that they had insulted a partner or deliberately made her feel bad about herself, 12.0% had deliberately done things to scare or intimidate a partner, 9.8% threatened to hurt a partner, 8.6% ever belittled or humiliated a partner in front of other people, and 4.4% had hurt people their partner cares about, or damaged things of importance to her, as a way of hurting her (Figure 7).

Table 15: Percentage of ever-partnered women aged 18 years and older who reported experiencing emotional abuse from their intimate partner(s) by socio-demographic characteristics, South Africa 2022

	Ever experienced one or more acts of emotional abuse[1]				Experienced one or more acts of emotional abuse in past 12 months[2]			
	%	95% CI	n	p-value	%	95% CI	n	p-value
Total	25.1	[22.8-27.5]	3 800		10.0	[8.6-11.7]	3 800	
Age group				0.003				<0.001
18–24	23.9	[17.6-31.5]	222		14.1	[8.7-22.1]	222	
25–34	29.9	[25.1-35.1]	679		13.4	[10.2-17.4]	679	
35–49	27.3	[23.4-31.5]	1 179		12.3	[9.6-15.6]	1 179	
50+	20.2	[17.4-23.4]	1 720		4.9	[3.7-6.3]	1 720	
Race				0.963				0.173
Black African	24.9	[22.6-27.3]	2 745		10.7	[9.2-12.5]	2 745	
Other race	25.1	[19.8-31.2]	1 044		8.0	[5.3-11.9]	1 044	
Current relationship status				0.025				<0.001
Currently married	21.3	[18.1-24.9]	1 867		9.5	[7.5-12.0]	1 867	
Cohabiting, not married	27.3	[21.1-34.6]	380		19.4	[14.0-26.1]	380	
Partner, not cohabiting	28.4	[23.1-34.3]	545		14.8	[11.1-19.5]	545	
No relationship	28.5	[24.2-33.1]	996		4.0	[2.4-6.5]	996	
Highest level of education				0.004				0.131
No formal schooling	16.5	[10.6-24.7]	207		4.1	[1.4-10.9]	207	
Primary school	21.5	[16.8-27.2]	623		7.6	[5.1-11.3]	623	
Secondary school	23.9	[21.3-26.8]	2 301		11.2	[9.3-13.3]	2 301	
Tertiary	31.0	[26.0-36.6]	663		9.7	[6.7-13.9]	663	
Employment status				0.002				0.951
Unemployed	23.0	[20.1-26.0]	2 099		10.4	[8.6-12.5]	2 099	
Employed	30.3	[26.5-34.4]	1 277		10.5	[8.0-13.5]	1 277	
Locality type				0.017				0.465
Urban	26.7	[23.9-29.6]	2 761		10.5	[8.7-12.5]	2 761	
Rural informal (tribal areas)	20.3	[16.6-24.6]	723		9.0	[6.6-12.0]	723	
Rural formal (farms)	23.8	[19.0-29.4]	316		8.9	[5.7-13.7]	316	

1. Had ever experienced any of the following: a) been insulted by a partner or deliberately made to feel bad about themselves, b) ever been scared or intimidated by a partner on purpose, c) ever been belittled or humiliated by a partner in front of other people, and d) their partner had ever verbally threatened to hurt them or someone they care about;
2. Reported yes to any of a-d above and that they had experienced any of these acts during the past 12 months.

Overall, 33.6% [95% CI: 31.0-36.3] of ever-partnered men had perpetrated one or more of these five acts of emotional abuse (Table 16). Perpetration of lifetime emotional abuse varied significantly by age and current relationship status. A significantly higher proportion of men aged 25–34 years perpetrated one or more acts of emotional abuse compared to their counterparts aged 50 years and older. Men who were cohabiting with a partner and not married reported a significantly higher proportion of perpetration of lifetime emotional abuse than men who were currently married.

Figure 7: Percentage of ever-partnered men aged 18 years and older who reported perpetrating different acts of emotional abuse against their intimate partner(s), South Africa, 2022

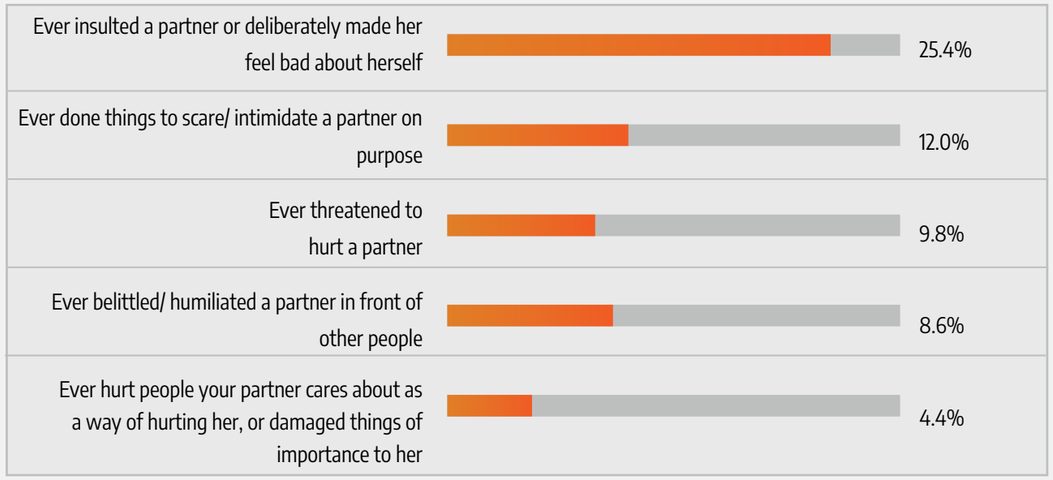


Table 16: Percentage of ever-partnered men aged 18 years and older who reported perpetrating emotional abuse against their intimate partner(s) by socio-demographic characteristics, South Africa, 2022

	Ever perpetrated one or more acts of emotional abuse[1]				Perpetrated one or more acts of emotional abuse in past 12 months[2]			
	%	95% CI	n	p-value	%	95% CI	n	p-value
Total	33.6	[31.0-36.3]	3383		7.2	[6.1-8.6]	3359	
Age group				0.010				<0.001
18–24	33.1	[26.6-40.2]	404		7.2	[4.7-10.9]	404	
25–34	39.0	[34.1-44.3]	795		11.6	[8.9-15.0]	787	
35–49	34.1	[30.1-38.3]	1111		7.3	[5.2-10.1]	1100	
50+	27.9	[23.8-32.5]	1071		2.7	[1.6-4.6]	1066	
Race				0.989				0.298
Black African	33.6	[30.8-36.5]	2765		7.6	[6.4-9.1]	2746	
Other race	33.7	[27.6-40.3]	618		5.6	[3.1-9.8]	613	
Current relationship status				0.002				<0.001
Currently married	29.0	[25.3-33.0]	1344		4.1	[2.6-6.4]	1333	
Cohabiting, not married	42.8	[36.4-49.6]	584		13.0	[9.3-17.8]	579	
Partner, not cohabiting	33.7	[29.9-37.6]	1267		8.7	[6.9-11.1]	1261	
No relationship	38.7	[28.6-49.8]	188		0.0	[0.0-0.0]	186	
Highest level of education				0.082				0.286
No formal schooling	16.6	[8.9-28.8]	84		1.2	[0.2-8.0]	84	
Primary school	30.9	[25.7-36.7]	541		5.5	[3.2-9.4]	536	
Secondary school	33.6	[30.6-36.8]	2170		7.6	[6.1-9.5]	2157	
Tertiary	37.1	[30.7-44.0]	520		7.4	[5.1-10.8]	514	
Employment status				0.099				0.570
Unemployed	31.4	[27.8-35.2]	1195		6.8	[5.0-9.1]	1191	
Employed	35.2	[32.0-38.5]	2169		7.6	[6.1-9.4]	2149	
Locality type				0.051				0.598
Urban	35.3	[31.9-39.0]	2076		7.1	[5.6-8.9]	2059	
Rural informal (tribal areas)	29.5	[25.6-33.8]	717		7.1	[5.3-9.6]	710	
Rural formal (farms)	33.2	[28.1-38.8]	590		9.1	[6.7-12.3]	590	

1. Had ever done any of the following: a) Ever insulted a partner or deliberately made her feel bad about herself; b) Ever belittled/humiliated a partner in front of other people; c) Ever done things to scare/intimidate a partner on purpose; d) Ever threatened to hurt a partner; e) Ever hurt people your partner cares about as a way of hurting her, or damaged things of importance to her;

2. Reported yes to any of a-e above and that they had done any of these acts during the past 12 months.

3.8.2. Recent emotional abuse victimisation and perpetration

In addition to measuring lifetime experiences of emotional abuse, we also measured recent experiences, defined as experiences of emotional abuse in the previous 12 months.

The proportion of women who reported experiencing one or more acts of recent emotional abuse was 10.0% [95% CI: 8.6-11.7]. Prevalence of recent emotional abuse varied significantly by age and current relationship status (Table 15). Experiences of one or more acts of emotional abuse were significantly higher among women aged 18–24, 25–34 and 35–49 years than for women aged 50 or older. Significantly higher proportions of women who were cohabiting but not married reported recent experiences of one or more acts of emotional abuse than women who were currently married or not currently in a relationship.

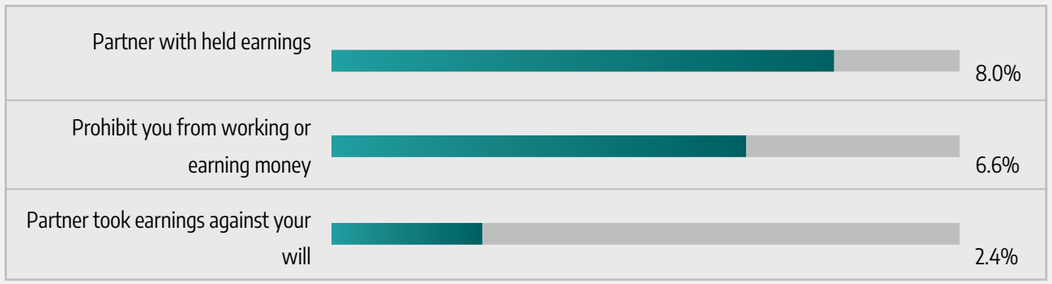
The proportion of men who reported perpetrating one or more recent acts of emotional abuse was 7.2% [95% CI: 6.1-8.6]. Prevalence of perpetration varied significantly by age and current relationship status (Table 16). Perpetration of one or more acts of emotional abuse was significantly higher among men aged 18–24, 25–34 and 35–49 years compared to men aged 50 years and older. Significantly higher proportions of men who had a partner and were not cohabiting and men who were cohabiting and not married reported perpetration of one or more recent acts of emotional abuse than men who were currently married.

3.9. Prevalence of economic abuse between intimate partners

3.9.1. Prevalence of lifetime economic abuse

Among women, economic abuse was measured using three items including a partner withholding his earnings, being prohibited from working, and a partner taking her earnings at any point in their lifetime. Partners withholding earnings were reported by 8.0% of ever-partnered women, 6.6% of women reported that a partner prohibited them from working or earning money, and 2.4% reported that a partner had taken their earnings against their will (Figure 8).

Figure 8: Percentage of ever-partnered women aged 18 years and older who reported experiencing economic abuse by their intimate partner(s) in their lifetime, South Africa, 2022



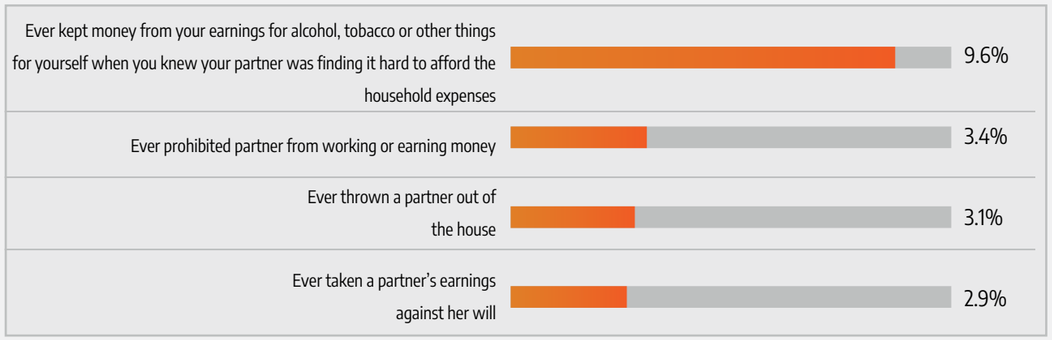
Overall, 13.1% [95% CI: 11.2-15.1] of ever-partnered women had experienced one or more acts of economic abuse by an intimate partner in their lifetime (Table 17). Experiences of economic abuse varied significantly by race, current relationship status, level of education, and locality. Black African women reported significantly higher proportions of experiencing one or more acts of economic abuse in their lifetime, when compared to the other race groups. Significantly higher proportions of women who were not currently in a relationship reported experiencing acts of economic abuse in their lifetimes compared to women who were married.

Table 17: Percentage of ever-partnered women aged 18 years and older who reported experiencing economic abuse by their intimate partner(s) by socio-demographic characteristics, South Africa, 2022

	Ever experienced one or more acts of economic abuse[1]				Experiences of one or more acts of economic abuse in past 12 months[2]			
	%	95% CI	n	p-value	%	95% CI	n	p-value
Total	13.1	[11.2-15.1]	3 804		4.5	[3.5-5.6]	3 804	
Age group				0.206				0.001
18–24	9.0	[4.9-15.9]	220		8.0	[4.1-14.8]	220	
25–34	12.2	[9.0-16.4]	681		4.4	[2.9-6.6]	681	
35–49	15.0	[12.2-18.4]	1 179		6.0	[4.3-8.3]	1 179	
50+	12.7	[10.7-15.0]	1 724		2.3	[1.6-3.3]	1 724	
Race				<0.001				<0.001
Black African	14.8	[12.6-17.4]	2 747		5.4	[4.2-6.9]	2 745	
Other race	7.7	[5.6-10.6]	1 046		1.6	[0.9-2.9]	1 044	
Current relationship status				<0.001				0.004
Currently married	9.3	[7.4-11.5]	1 867		4.0	[2.7-5.7]	1 867	
Cohabiting, not married	13.1	[9.4-18.1]	381		7.2	[4.4-11.4]	381	
Partner, not cohabiting	12.9	[9.2-17.8]	545		7.3	[4.8-11.1]	545	
No relationship	19.9	[16.0-24.5]	999		2.3	[1.2-4.4]	999	
Highest level of education				0.035				0.066
No formal schooling	14.3	[8.9-22.0]	207		2.1	[0.4-10.0]	207	
Primary school	16.0	[12.1-20.9]	625		6.8	[3.8-11.6]	625	
Secondary school	13.9	[11.6-16.6]	2 303		4.9	[3.7-6.4]	2 303	
Tertiary	9.3	[6.7-12.9]	663		2.7	[1.6-4.5]	663	
Employment status				0.916				0.721
Unemployed	13.4	[10.9-16.3]	2 103		4.6	[3.3-6.5]	2 103	
Employed	13.6	[11.1-16.6]	1 278		5.0	[3.7-6.8]	1 278	
Locality type				0.007				0.068
Urban	11.7	[9.6-14.3]	2 766		3.8	[2.9-5.0]	2 766	
Rural informal (tribal areas)	17.4	[14.0-21.4]	722		6.3	[4.0-9.6]	722	
Rural formal (farms)	11.1	[7.0-17.1]	316		6.3	[3.2-12.1]	316	

1. Had ever experienced any of the following: a) Partner prohibited you from working or earning money; b) Partner took your earnings against your will; c) Partner withheld his earnings;
2. Reported yes to any of a-c above and that they had experienced any of these acts during the past 12 months.

Figure 9: Percentage of ever-partnered men aged 18 years and older who reported perpetrating different acts of economic abuse against their intimate partner(s) during their lifetime, South Africa, 2022



Further to the three items listed above, an additional item (throwing a partner out of the house) was used to measure perpetration of economic abuse of an intimate partner by men at any point in their lifetime. Withholding one's earnings when they knew their partner was finding it hard to afford the household expenses was reported by 9.6% of ever-partnered men, while lower proportions of men reported ever having prohibited partner from working or earning money (3.4%), having thrown a partner out of the house (3.1%), and having taken a partner's earnings against her will (2.9%) (Figure 9).

Overall, 14.8% [95% CI: 13.0-16.8] of ever-partnered men reported perpetrating one or more of these four acts of economic abuse in their lifetime (Table 18). Perpetration of economic abuse varied significantly by age, race, and current relationship status. Men aged 25–34 years (21.3%) reported significantly higher proportions of perpetrating one or more acts of economic abuse than men aged 18–24 (12.4%), 35–49 (13.8%), or 50 years and older (11.0%). Black African men reported significantly higher proportions of perpetrating one or more acts of economic abuse in their lifetime than men of other race groups. Significantly higher proportions of men who were cohabiting but not married reported perpetrating one or more acts of economic abuse than men who were currently married.

3.9.2. Prevalence recent economic abuse

In addition to measuring lifetime experiences of economic abuse, we also measured recent experiences, defined as experiences of economic abuse in the past 12 months. The proportion of ever-partnered women who experienced recent economic abuse was 4.5% [95% CI: 3.5-5.6] with prevalence varying significantly by age, race, and current relationship status (Table 17). Recent experiences of one or more acts of economic abuse were significantly higher among women aged 18–24 and 35–49 than women of 50 years and older. Women who had a partner but were not cohabiting reported a significantly higher proportion of recent experiences of one or more acts of economic abuse than women who were not currently in a relationship. Black African women reported a significantly higher proportion of recent experiences of one or more acts of economic abuse than women from other race groups.

The proportion of ever-partnered men who reported perpetrating economic abuse recently was 5.3% [95% CI: 4.3-6.5]. The prevalence varied significantly by age, current relationship status, and locality type (Table 18). Recent perpetration of one or more acts of economic abuse was significantly higher among men aged 18–24, 25–34 and 35–49 than men aged 50 years and older. Men who were cohabiting with a partner but not married reported a significantly higher proportion of recent perpetration of one or more acts of economic abuse than men who were currently married. Men residing in rural informal areas reported a significantly higher proportion of recent perpetration of one or more acts of economic abuse than men in urban areas.

Table 18: Percentage of ever-partnered men aged 18 years and older who reported perpetrating economic abuse against their intimate partner(s) by socio-demographic characteristics, South Africa, 2022

	Ever perpetrated an act of economic abuse[1]				Perpetrated economic abuse in past 12 months[2]			
	%	95% CI	n	p-value	%	95% CI	n	p-value
Total	14.8	[13.0-16.8]	3 369		5.3	[4.3-6.5]	3 365	
Age group				<0.001				<0.001
18-24	12.4	[9.0-16.8]	402		6.8	[4.4-10.2]	402	
25-34	21.3	[17.2-26.1]	789		8.2	[5.8-11.6]	787	
35-49	13.8	[11.5-16.4]	1 110		5.1	[3.8-6.9]	1 109	
50+	11.0	[8.7-13.9]	1 066		2.0	[1.2-3.1]	1 065	
Race				0.001				0.125
Black African	16.4	[14.2-18.8]	2 745		5.8	[4.7-7.1]	2 741	
Other race	8.5	[5.8-12.3]	623		3.4	[1.7-6.5]	623	
Current relationship status				0.013				<0.001
Currently married	11.4	[9.4-13.8]	1 336		3.5	[2.3-5.2]	1 335	
Cohabiting, not married	19.0	[14.8-24.1]	590		9.2	[6.3-13.3]	590	
Partner, not cohabiting	16.2	[13.2-19.7]	1 260		6.1	[4.5-8.1]	1 257	
No relationship	15.2	[9.0-24.5]	183		0.6	[0.1-3.4]	183	
Highest level of education				0.867				0.566
No formal schooling	11.8	[6.0-22.0]	82		1.3	[0.3-5.5]	82	
Primary school	14.5	[10.9-18.9]	540		5.3	[3.4-8.1]	540	
Secondary school	15.1	[12.8-17.7]	2 165		5.3	[4.3-6.6]	2 162	
Tertiary	14.0	[10.5-18.4]	517		5.8	[3.5-9.7]	516	
Employment status				0.931				0.601
Unemployed	14.7	[11.9-18.2]	1 182		5.0	[3.6-6.8]	1 181	
Employed	14.9	[12.7-17.4]	2 166		5.6	[4.3-7.1]	2 163	
Locality type				0.067				<0.001
Urban	13.5	[11.3-16.0]	2 071		3.9	[3.0-5.2]	2 070	
Rural informal (tribal areas)	18.0	[14.3-22.3]	706		8.5	[6.2-11.6]	704	
Rural formal (farms)	15.3	[11.4-20.3]	592		6.2	[4.1-9.3]	591	

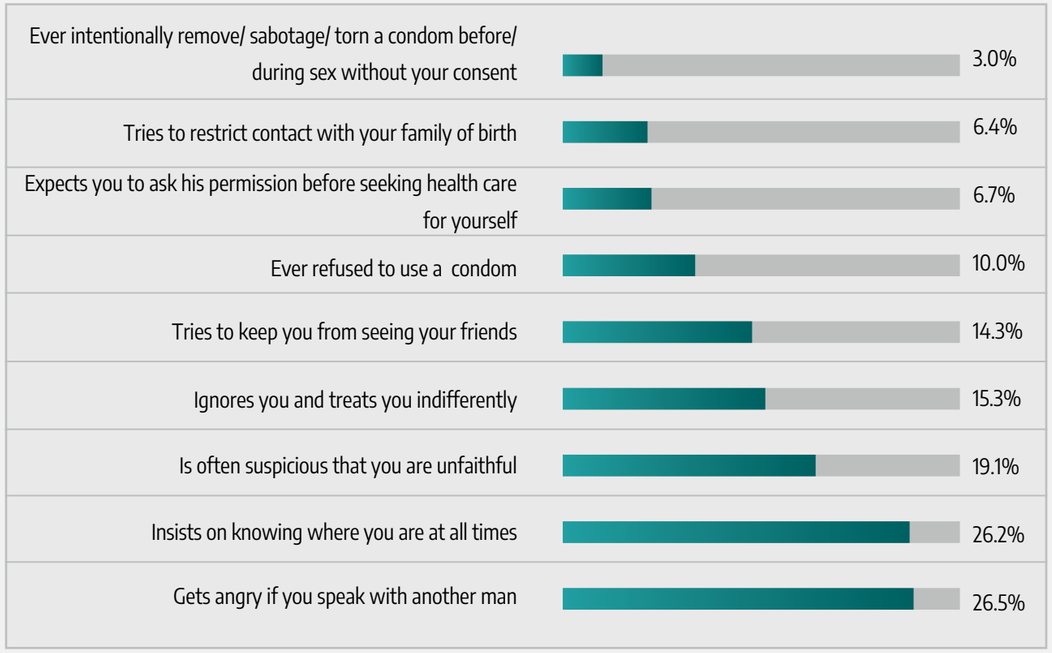
1. Had ever done any of the following: a) Ever prohibited partner from working or earning money; a) Ever taken a partner's earnings against her will; b) Ever thrown a partner out of the house; d) Ever kept money from your earnings for alcohol, tobacco or other things for yourself when you knew your partner was finding it hard to afford the household expenses;
2. Reported yes to any of a-d above and that they had done any of these acts during the past 12 months.

3.10. Prevalence of controlling behaviour between intimate partners

Evidence has shown that controlling behaviour is a part of IPV and are a form of psychological abuse. Women who had ever had a partner were asked whether they had ever experienced any form of controlling behaviours in their relationships. They were provided with a list of behaviours and had to indicate the behaviour that they had experienced from a partner.

The behaviours that the highest proportion of women experienced were that their partner got angry if they spoke to another man (26.5%) and that their partner insisted on knowing where they were at all times (26.2%) (Figure 10). These were followed by 19.1% of women who experienced that their partner was often suspicious that they were unfaithful, 15.3% whose partner ignored and treated them indifferently, and 14.3% whose partner tried to stop them from seeing their friends.

Figure 10: Percentage of ever-partnered women aged 18 years and older who reported experiencing controlling behaviours by an intimate partner, South Africa, 2022



Overall, 57.6% [95% CI: 54.4-60.7] of women have experienced controlling behaviours, which varied significantly by age, race, current relationship status, and locality (Table 19). Experiences of controlling behaviour were significantly higher among women aged 18–24, 25–34 and 35–49 years than women aged 50 years and older and were also significantly higher among Black African women than those from other race groups. Women who were cohabiting but not married, women who had a partner but were not cohabiting, and women who were not currently in a relationship reported a significantly higher proportion of experiences of controlling behaviour than women who were currently married. Women who resided in rural informal (tribal areas) reported a significantly higher proportion of experiences of controlling behaviour than women residing in urban areas.

Table 19: Percentage of ever-partnered women aged 18 and above who reported experiencing various controlling behaviours by an intimate partner, South Africa 2022

	Experience of controlling behaviour[1]			
	%	95% CI	N	p-value
Total	57.6	[54.4-60.7]	3 085	
Age group				<0.001
18–24	76.2	[68.4-82.5]	214	
25–34	62.7	[56.1-68.8]	646	
35–49	57.9	[53.1-62.7]	1 036	
50+	45.9	[41.3-50.5]	1 189	
Race				<0.001
Black African	64.7	[61.6-67.7]	2 293	
Other race	33.1	[26.9-40.1]	785	
Highest level of education				0.328
No formal schooling	54.4	[43.8-64.6]	136	
Primary school	58.8	[51.6-65.7]	428	
Secondary school	59.0	[55.1-62.8]	1 969	
Tertiary	53.9	[47.7-59.9]	548	
Employment status				0.154
Unemployed	55.3	[51.2-59.4]	1 702	
Employed	59.5	[54.9-63.8]	1 069	
Current relationship status				<0.001
Currently married	44.4	[40.1-48.8]	1 413	
Cohabiting, not married	63.2	[55.8-69.9]	348	
Partner, not cohabiting	72.1	[66.3-77.2]	545	
No relationship	64.6	[59.2-69.7]	770	
Locality type				0.001
Urban	54.8	[50.9-58.7]	2 251	
Rural informal (tribal areas)	65.9	[60.4-71.0]	570	
Rural formal (farms)	59.0	[52.0-65.7]	264	

1. Experienced any of the following from a partner: a) Tries to keep you from seeing your friends; b) Tries to restrict contact with your family of birth; c) Insists on knowing where you are at all times; d) Ignores you and treats you indifferently; e) Gets angry if you speak with another man; f) Is often suspicious that you are unfaithful; g) Expects you to ask his permission before seeking health care for yourself; h) Ever refused to use a condom; i) Ever intentionally remove/sabotage/torn a condom before/during sex without your consent?

Men who ever had a partner were asked whether they agreed or disagreed with statements about controlling behaviour in their current or most recent relationship. Forty-four per cent of men agreed or strongly agreed with the statement: 'When I want sex, I expect my partner to agree' (Figure 11). This was followed by 37.7% of men who agreed that they would not let their partners wear certain things, 32.8% who wanted to know where their partners are all the time, and 31.3% who agreed that they have more to say than their partners do about important decisions that affect them.

Overall, 77.2% [95% CI: 74.7-79.4] of men agreed with one or more of the statements about controlling behaviour, which varied significantly by age, race, and current relationship status (Table 20). Controlling behaviour was significantly higher among men aged 18–24 (80.2%), 25–34 (81.2%) and 35–49 (78.4%) years compared to those aged 50 years and older (70.1%), and were also significantly higher among Black African men than those from other race groups. Men who had a partner but were not cohabiting reported a significantly higher proportion of controlling behaviour than men who were currently married. Men who were cohabiting but not married reported a higher proportion of controlling behaviour compared to men who were currently married.

Figure 11: Percentage of ever-partnered men aged 18 and above who reported agreeing with various statements on controlling behaviour in their current or most recent relationship, South Africa, 2022

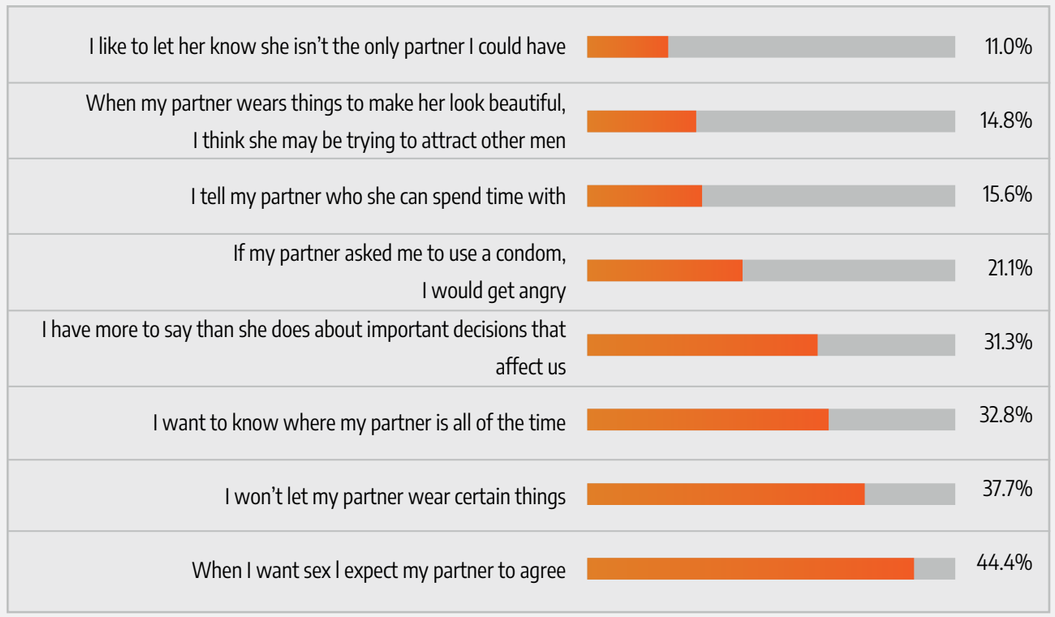


Table 20: Percentage of ever-partnered men aged 18 years and older who agreed with statements on controlling behaviour in their current or most recent relationship, South Africa, 2022

	Agreed with any statement about controlling behaviour[1]			
	%	95% CI	n	p-value
Total	77.2	[74.7-79.4]	3 412	
Age group				0.001
18–24	80.2	[74.2-85.1]	399	
25–34	81.2	[76.5-85.2]	807	
35–49	78.4	[74.4-82.0]	1 117	
50+	70.1	[65.9-74.0]	1 087	
Race				<0.001
Black African	79.7	[77.3-81.9]	2 801	
Other race	66.6	[59.3-73.1]	609	
Current relationship status				0.008
Currently married	72.5	[68.3-76.3]	1 358	
Cohabiting, not married	80.1	[74.3-84.9]	592	
Partner, not cohabiting	80.1	[76.7-83.2]	1 279	
No relationship	78.3	[69.8-84.9]	183	
Highest level of education				0.442
No formal schooling	73.6	[59.0-84.4]	82	
Primary school	77.6	[71.2-82.9]	558	
Secondary school	78.3	[75.4-80.9]	2 179	
Tertiary	74.2	[68.9-78.9]	529	
Employment status				0.920
Unemployed	77.1	[73.4-80.4]	1 206	
Employed	77.3	[74.3-80.1]	2 184	
Locality type				0.086
Urban	75.5	[72.3-78.5]	2 093	
Rural informal (tribal areas)	80.5	[76.4-84.0]	721	
Rural formal (farms)	80.1	[72.3-86.1]	598	

1. Agreed or strongly agreed with any of the following statements: a) When I want sex, I expect my partner to agree; b) If my partner asked me to use a condom, I would get angry; c) I won't let my partner wear certain things; d) I have more to say than she does about important decisions that affect us; e) I tell my partner who she can spend time with; f) When my partner wears things to make her look beautiful, I think she may be trying to attract other men; g) I want to know where my partner is all of the time; h) I like to let her know she isn't the only partner I could have.

3.11. IPV-related injuries among women

As part of understanding the impact of GBV, the study also inquired about injuries due to IPV. Women were requested to indicate the frequency of injuries due to IPV and the frequency with which they sought services from health care providers for these injuries.

Among the ever-partnered women who reported having experienced physical or sexual IPV, 711 answered the question on whether they were injured as a result of the IPV. Of these 711 women, 41.6% [95% CI: 35.9-47.5] reported that they had been injured as a result of IPV. Among those who reported being injured (n=324), a large proportion reported that they were injured once (38.8%), 35.6% reported that they were injured two to five times, and 25.7% reported that they were injured more than five times (Figure 12). More than half (55.8%) of the women reported that they did not require health care as a result of their injuries. However, 23.3% reported that they needed health care once, 15.1% needed health care two to five times, and 5.8% reported that they needed health care more than five times, even if they didn't receive it (Figure 13).

Figure 12: Percentage of ever-partnered women aged 18 years and older who experienced physical and/or sexual IPV and reported the frequency of injuries due to IPV, South Africa, 2022

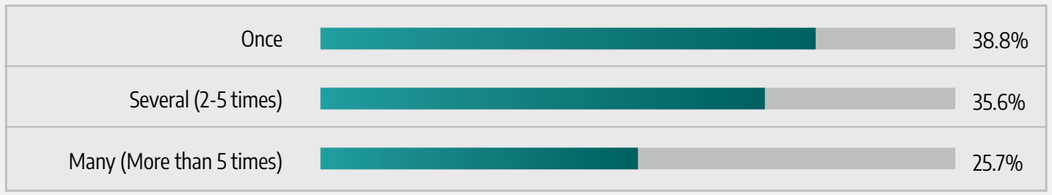
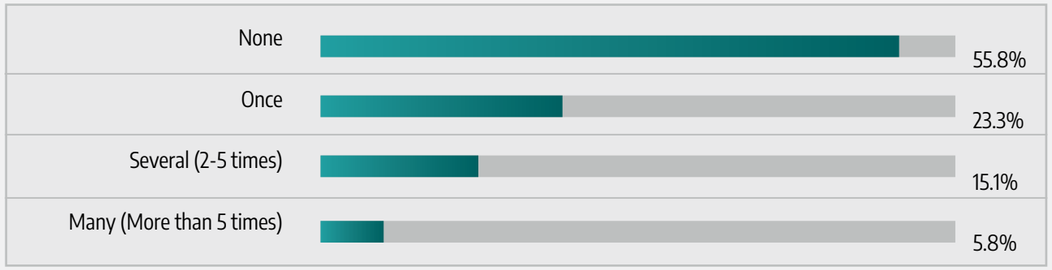


Figure 13: Percentage of ever-partnered women aged 18 years and older who experienced physical and/or sexual IPV and frequency of help-seeking due to IPV-related injuries, South Africa, 2022

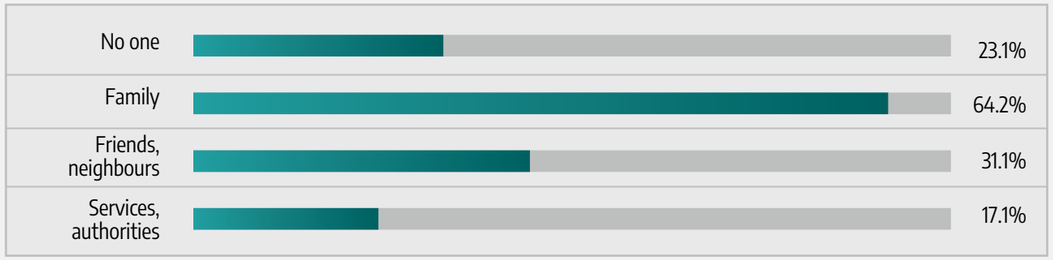


3.12. Disclosure of IPV and help-seeking behaviour among women

The study further explored the impact of GBV on women's help-seeking behaviour by requesting women to indicate to whom they reported their experience of IPV. Among women who had experienced IPV and answered the questions on who they told about the IPV (n=715), 64.2% reported that they told family, 31.1% told friends and neighbours, and only 17.1% told authorities or services about their experience of violence. About 23.1% of women indicated that they did not disclose their experiences to anyone (Figure 14).

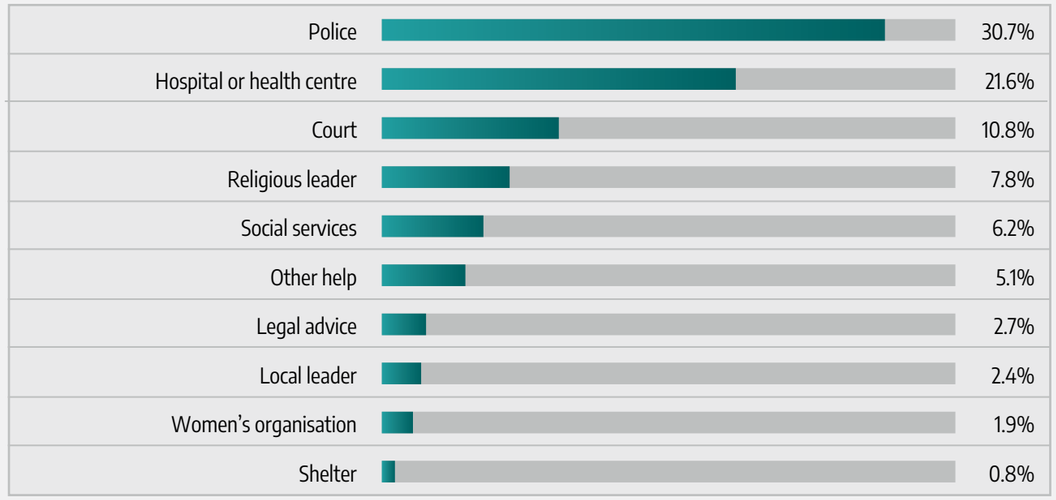
Women who experienced IPV were also asked if they ever requested assistance from the authorities or any services because of the IPV. A large proportion of women (30.7%) reported that they visited the police, followed by hospitals or heath centres (21.6%), and courts (10.8%). Some reported that they contacted religious leaders (7.8%) and social services (6.2%). Very few women reported that they visited shelters (0.8%), women's organisations (1.9%), contacted local leaders (2.4%) or sought legal advice (2.7%) (Figure 15).

Figure 14: Percentage of ever-partnered women aged 18 years and older who experienced physical and/or sexual IPV and choices of disclosure of their experience of violence, South Africa, 2022



Multiple response options were possible

Figure 15: Percentage of ever-partnered women aged 18 years and older who experienced physical and/or sexual IPV and their utilisation of support services, South Africa, 2022



3.13. Prevalence of lifetime non-partner violence: victimisation among women

To assess experiences of non-partner violence, all women were asked if anyone had perpetrated any forms of physical and/or sexual violence against them since the age of 15 years. If they responded yes, they were asked who had perpetrated these forms of violence, with options provided for various family members, acquaintances, and other non-partners.

3.13.1. Prevalence of lifetime non-partner physical violence

Overall, 24.6% [95% CI: 22.5-26.8] of women reported experiencing physical violence by a non-partner. The prevalence varied significantly by age, race, and current relationship status (Table 21). This translates to an estimated 5 417 522 women who experienced physical violence by a non-partner (Appendix H). Having experienced physical violence was significantly higher for women aged 18–24, 25–34 and 35–49 than women aged 50 years and older, and also for Black African women compared to those of other race groups. It was significantly higher for women who were cohabiting but not married, those who had a partner but were not cohabiting, and those who were not currently in a relationship compared to than for those who were currently married.

When women were asked how often they experienced these forms of violence, 35.6% reported once, while 32.3% reported a few times, and 32.1% reported that they experienced it many times (Figure 16). Family members were the most frequently identified perpetrators of non-partnered physical violence (31.1%), followed by friends or acquaintances (11.7%), and other people (7.6%) (Figure 17). Strangers were the least reported perpetrators of physical violence (1.8%).

3.13.2. Prevalence of lifetime non-partner sexual violence

Sexual violence by a non-partner was 5.9% [95% CI: 5.0-6.9] (Table 21), which translates to an estimated 1 278 011 women having experienced sexual violence by a non-partner in their lifetime (Appendix H). Women who were cohabiting but not married experienced a significantly higher proportion of sexual violence by a non-partner compared to women who were currently married.

3.13.3. Prevalence of lifetime non-partner physical and/or sexual violence

Lifetime physical and/or sexual violence were reported by 27.0% [95% CI: 24.8-29.3] of women (Table 21), which translates to an estimated 5 948 915 women having experienced physical and/or sexual violence by a non-partner (Appendix H). The prevalence varied significantly by age, race, and current relationship status. Having experienced either physical and/or sexual violence was significantly higher among women aged 18–24, 25–34 and 35–49 years than for women aged 50 years and older, and among Black African women compared to those of other race groups. Reported acts of sexual violence by a non-partner were also significantly higher among women who were cohabiting but not married, those who had a partner but were not cohabiting, and those who were not currently in a relationship than those who were currently married.

Table 21: Percentage of all women aged 18 years and older who reported ever experiencing non-partner physical and/or sexual violence in their lifetime, South Africa, 2022

	Ever experienced physical violence[1]				Ever experienced sexual violence[2]				Ever experienced both physical and /or sexual violence[3]			
	%	95% CI	N	p-value	%	95% CI	n	p-value	%	95% CI	n	p-value
Total	24.6	[22.5-26.8]	5 536		5.9	[5.0-6.9]	5 491		27.0	[24.8-29.3]	5 550	
Age group				<0.001				0.158				<0.001
18–24	31.2	[26.0-37.0]	583		5.4	[3.3-8.9]	577		34.0	[28.6-39.9]	584	
25–34	27.1	[23.5-31.1]	1 173		7.1	[5.3-9.4]	1 159		29.5	[25.8-33.4]	1 176	
35–49	25.2	[22.1-28.7]	1 621		6.5	[5.0-8.5]	1 608		27.8	[24.5-31.3]	1 627	
50+	18.2	[15.6-21.0]	2 159		4.4	[3.4-5.6]	2 147		20.1	[17.6-23.0]	2 163	
Race				<0.001				0.279				<0.001
Black African	26.8	[24.4-29.3]	4 205		6.1	[5.1-7.3]	4 167		29.1	[26.6-31.7]	4 213	
Other race	15.9	[12.7-19.9]	1 316		4.9	[3.3-7.1]	1 309		18.5	[15.0-22.7]	1 322	
Highest level of education				0.408				0.640				0.531
No formal schooling	18.1	[11.5-27.3]	307		3.9	[1.8-8.2]	308		21.1	[14.0-30.4]	310	
Primary school	25.3	[21.0-30.1]	829		5.1	[3.6-7.3]	826		27.7	[23.3-32.6]	830	
Secondary school	24.4	[22.0-27.0]	3 440		6.1	[5.0-7.6]	3 407		26.8	[24.3-29.5]	3 448	
Tertiary	26.1	[21.7-30.9]	950		5.8	[4.2-8.1]	940		28.2	[23.6-33.2]	952	
Employment status				0.805				0.320				0.837
Unemployed	24.3	[21.6-27.1]	3 093		5.7	[4.5-7.1]	3 071		26.7	[24.0-29.7]	3 102	
Employed	24.8	[21.7-28.2]	1 792		6.7	[5.3-8.6]	1 779		27.2	[24.0-30.6]	1 795	
Current relationship status				<0.001				0.022				<0.001
Currently married	17.6	[15.1-20.3]	1 934		4.5	[3.4-6.0]	1 923		19.5	[16.9-22.4]	1 938	
Cohabiting, not married	31.3	[25.4-37.9]	580		9.6	[6.5-13.9]	574		36.2	[30.1-42.8]	582	
Partner, not cohabiting	30.8	[26.5-35.5]	945		6.8	[4.8-9.4]	934		33.3	[28.9-38.0]	946	
No relationship	24.3	[21.2-27.7]	1 997		5.6	[4.3-7.4]	1 982		26.4	[23.2-29.9]	2 002	
Locality type				0.050				0.496				0.074
Urban	26.1	[23.5-28.8]	3 943		6.1	[5.1-7.4]	3 897		28.4	[25.7-31.2]	3 952	
Rural informal (tribal areas)	21.0	[17.5-25.1]	1 078		5.3	[3.7-7.5]	1 075		23.6	[19.8-27.9]	1 079	
Rural formal (farms)	22.3	[16.8-29.1]	515		4.7	[2.9-7.5]	519		23.9	[18.4-30.4]	519	

1. Any one or more of the following: Since the age of 15 until now a) Slapped, hit, beaten, kicked or done anything else to hurt you, b) Thrown something at you? Pushed you or pulled your hair; c) Choked or burnt you on purpose; d) Threatened with or actually used a gun, knife or other weapon against you;
2. Any one or more of the following: Since the age of 15 until now, has anyone (other than your male partner) a) Ever forced you into a sexual act when you did not want to, for example by threatening you, holding you down, or putting you in a situation where you could not say no; b) Ever forced you to have sex when you were too drunk or drugged to refuse;
3. 1 and/or 2.

3.14. Prevalence of recent non-partner violence: victimisation among women

To assess recent experiences of non-partner violence, all women were asked if anyone had perpetrated any forms of physical and/or sexual violence against them in the 12 months prior to the survey.

3.14.1. Prevalence of non-partner physical violence in the past 12 months

Overall, 3.4% [95% CI: 2.5-4.4] of women reported recently experiencing physical violence by a non-partner, which translates to an estimated 738 407 women who recently experienced physical violence by a non-partner (Appendix H). Reports of victimisation varied significantly by age, race, current relationship status, and locality type (Table 22). Non-partner physical violence victimisation was significantly higher among women aged 18–24 and 25–34 than for those aged 35–49 years and 50 years and older. Prevalence was also significantly higher among women who were cohabiting but not married, those who had a partner but were not cohabiting, and those who were not currently in a relationship compared to those who were currently married. A higher proportion of women who resided in urban areas reported that they had recently experienced physical violence by a non-partner than women who resided in rural areas.

3.14.2. Prevalence of non-partner sexual violence in the last 12 months

Sexual violence by a non-partner in the last 12 months was 0.6% [95% CI: 0.4-0.9] (Table 22), which translates to an estimated 124 438 women who recently experienced sexual violence by a non-partner (Appendix H). Black African women experienced a higher proportion of recent sexual violence by a non-partner compared to women from other race groups.

3.14.3. Prevalence of recent non-partner physical and/or sexual violence

The prevalence of physical and/or sexual violence by a non-partner was 3.7% [95% CI: 2.8-4.7] among women (Table 22), which translates to an estimated 807 260 women who were recently physical and/or sexually violated by a non-partner (Appendix H). Prevalence varied significantly by age, race, current relationship status, and locality type. Recent non-partner physical and/or sexual violence victimisation was significantly higher among women aged 18–24 and 25–34 years than for those aged 35–49 years and 50 years and older. It was also significantly higher among women who were cohabiting but not married, those who had a partner but were not cohabiting, and those who were not currently in a relationship compared to those who were currently married. A higher proportion of women who resided in urban areas reported that they had recently experienced physical violence by a non-partner than women who resided in rural areas.

Table 22: Percentage of all women aged 18 years and older who reported experiencing physical and/or sexual violence by a non-partner during the past 12 months, South Africa, 2022

	Recently experienced physical violence (non-partner)[1]				Recently experienced sexual violence (non-partner)[2]				Recently experienced both physical and/or sexual violence (non-partner)[3]			
	%	95% CI	N	p-value	%	95% CI	n	p-value	%	95% CI	n	p-value
Total	3.4	[2.5-4.4]	5 531		0.6	[0.4-0.9]	5 489		3.7	[2.8-4.7]	5 549	
Age group				<0.001				0.055				<0.001
18-24	7.6	[4.6-12.5]	582		0.7	[0.2-1.9]	577		8.2	[5.0-13.0]	584	
25–34	4.9	[3.3-7.2]	1 173		1.1	[0.5-2.1]	1 158		5.3	[3.7-7.6]	1 176	
35–49	1.6	[1.0-2.6]	1 620		0.6	[0.2-1.5]	1 607		1.9	[1.2-3.0]	1 627	
50+	1.4	[0.6-3.1]	2 156		0.1	[0.0-0.5]	2 147		1.5	[0.7-3.1]	2 162	
Race				0.039				<0.001				0.019
Black African	3.8	[2.8-5.1]	4 202		0.7	[0.4-1.1]	4 165		4.1	[3.2-5.4]	4 213	
Other race	1.8	[0.9-3.5]	1 314		0.1	[0.0-0.4]	1 309		1.8	[0.9-3.5]	1 321	
Highest level of education				0.394				0.197				0.276
No formal schooling	3.8	[0.6-22.3]	307		0.0		308		3.8	[0.5-22.2]	310	
Primary school	1.7	[0.8-3.5]	828		0.2	[0.1-0.6]	826		1.9	[0.9-3.6]	830	
Secondary school	4.0	[3.0-5.4]	3 436		0.8	[0.5-1.3]	3 405		4.5	[3.4-5.9]	3 447	
Tertiary	2.3	[1.0-5.2]	950		0.3	[0.1-1.3]	940		2.3	[1.0-5.2]	952	
Employment status				0.780				0.901				0.695
Unemployed	3.1	[2.2-4.5]	3 089		0.7	[0.4-1.2]	3 071		3.5	[2.6-4.9]	3 101	
Employed	2.9	[1.8-4.7]	1 792		0.6	[0.3-1.4]	1 777		3.2	[2.0-5.0]	1 795	
Current relationship status				0.005				0.112				0.003
Currently married	1.4	[0.8-2.5]	1 934		0.2	[0.1-0.7]	1 923		1.6	[0.9-2.7]	1 938	
Cohabiting, not married	4.6	[2.6-7.9]	579		1.1	[0.4-3.4]	574		5.7	[3.5-9.2]	581	
Partner, not cohabiting	3.9	[2.6-6.0]	945		1.0	[0.4-2.4]	933		4.3	[2.9-6.5]	946	
No relationship	4.3	[2.8-6.7]	1 995		0.5	[0.2-1.1]	1 981		4.5	[2.9-6.8]	2 002	
Locality type				0.011				0.535				0.015
Urban	4.0	[2.9-5.4]	3 938		0.6	[0.4-1.1]	3 896		4.3	[3.2-5.7]	3 951	
Rural informal (tribal areas)	1.8	[1.1-3.1]	1 078		0.4	[0.1-1.1]	1 075		2.1	[1.2-3.5]	1 079	
Rural formal (farms)	2.8	[1.6-4.9]	515		0.5	[0.2-1.6]	518		3.1	[1.8-5.5]	519	

1. Any one or more of the following: Since the age of 15 until now a) Slapped, hit, beaten, kicked or done anything else to hurt you, b) Thrown something at you? Pushed you or pulled your hair; c) Choked or burnt you on purpose; d) Threatened with or actually used a gun, knife or other weapon against you;
2. Any one or more of the following: Since the age of 15 until now, has anyone (other than your male partner) a) Ever forced you into a sexual act when you did not want to, for example by threatening you, holding you down, or putting you in a situation where you could not say no; b) Ever forced you to have sex when you were too drunk or drugged to refuse;
3. 1 and/or 2.

Figure 16: Frequency of physical violence among women aged 18 years and older reporting non-partner physical violence, South Africa, 2022

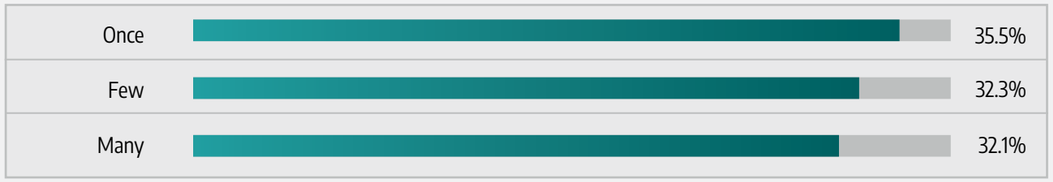
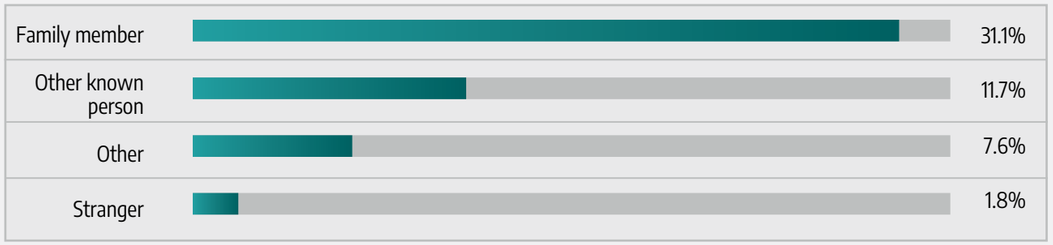


Figure 17: Categories of perpetrators of physical violence among women aged 18 years and older reporting non-partner physical violence, South Africa, 2022



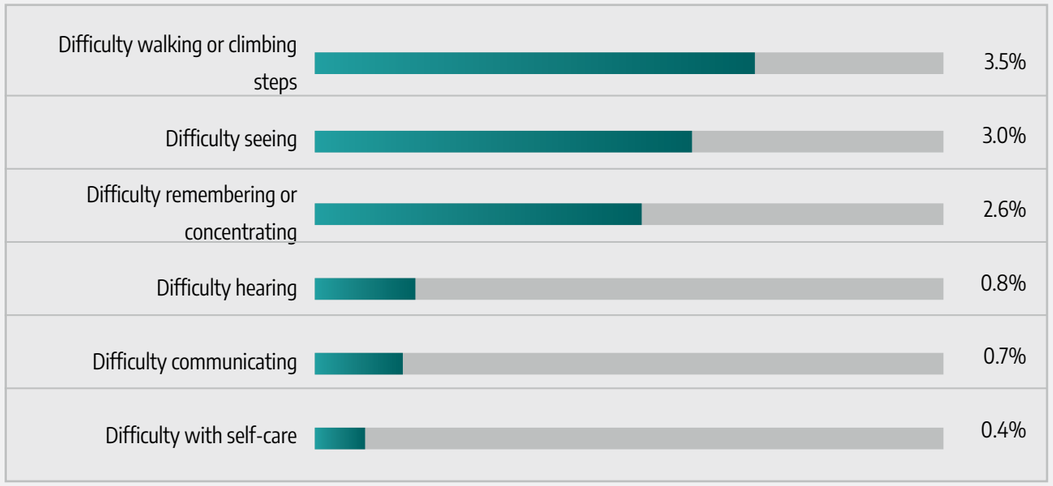
Family: parent, sibling, parent in-law, other family member.
Stranger: teacher, health care worker, religious leader, police.
Other known person: friend, acquaintance.
Other: any other person.

3.15. Prevalence of GBV among women with disabilities

3.15.1. Overall disabilities among women regardless of partnered status

Overall, 7.7% [95% CI: 6.8-8.7] of women aged 18 years and older had a disability. Disability was measured using the Washington Group on Disability Statistics (WG) (Appendix B). The most common type of disability was difficulty walking or climbing steps [3.5%, 95% CI:2.9-4.3] followed by difficulty seeing even if wearing glasses [3.0%, 95% CI: 2.5-3.6]. The least common form of disability was difficulty with self-care [0.4% [95% CI: 0.2-0.7] (Figure 18).

Figure 18: Prevalence of various types of disabilities among women aged 18 years and older, South Africa, 2022



3.15.2. Physical and sexual violence among women with disabilities

A higher proportion of women with disabilities [40.4%, 95% CI: 34.6-46.5] had experienced physical violence in their lifetime than women without disabilities [32.5%, 95% CI: 30.2-34.9]. Weighted numbers are provided in (Appendix K). The prevalence of lifetime sexual violence was significantly higher among women with disabilities [15.3%, 95% CI: 11.5-20.0], than for women without disabilities [9.3%, 95% CI: 8.1-10.6]. The prevalence of lifetime physical and/or sexual violence was higher among women with disabilities [42.5%, 95% CI: 36.5-48.7] than for women without disabilities [34.9%, 95% CI: 32.6-37.4].

With regard to the prevalence of violence among all women in the past 12 months, there were no significant differences between women with and women without disabilities. However, a higher proportion of women with disabilities [2.6%, 95% CI: 1.3-5.3] reported recent sexual violence than women with no disabilities [1.9%, 95% CI: 1.4-2.4], while a higher proportion of women without a disabilities reported experiencing recent physical violence [6.2%, 95% CI: 5.1-7.4] and physical and/or sexual violence [7.1%, 95% CI: 5.9-8.4] than women with a disabilities [4.3%, 95% CI: 2.4-7.5] and [5.3%, 95% CI: 3.2-8.7], respectively (weighted numbers are provided in Appendix K).

Furthermore, 62.3% [95% CI: 55.5-68.6] of women with a current disability reported a history of physical childhood abuse before age 15, compared to women without a disability 57.7% [95% CI: 54.7-60.6]. This translates to an estimated 981 166 women with disabilities who have experienced childhood physical abuse before the age of 15 years (Appendix K). A similar proportion of women with a current disability, 4.2% [95% CI: 2.3-7.6] reported a history of sexual child abuse before age 15 compared to women without a current disability [4.0%, 95% CI: 3.0-5.3]. This translates to an estimated 71 471 women with a disability who have experienced childhood sexual abuse.

3.15.3. Prevalence of disabilities among ever-partnered women

Among ever-partnered women, 7.8% [95% CI: 6.9-8.9] had a disability, which was defined as having difficulty with one or more of the following: seeing, hearing, walking or climbing steps, remembering or concentrating, communicating, and self-care.

3.15.4. Prevalence of IPV among ever-partnered women with disabilities

The prevalence of lifetime physical violence, sexual violence, physical and /or sexual violence, emotional abuse, economic abuse and controlling behaviour by a partner were higher among ever-partnered women with disabilities compared to women who did not report disabilities (Table 23). Weighted numbers are provided in Appendix K. Among ever-partnered women with disabilities, the prevalence of lifetime physical violence by a partner was 29.3% [95% CI: 23.4-36.0], sexual violence was 14.6%, [95% CI: 10.1-20.6], physical and/or sexual violence was 31.2 [95% CI: 25.2-38.0], emotional abuse was 31.9% [95% CI: 25.7-38.7], economic abuse was 16.3% [95% CI: 12.0-21.7], and reported controlling behaviours were 60.0% [95% CI: 50.5-68.8]. The prevalence of lifetime sexual violence by a partner was significantly higher among ever-partnered women with disabilities [14.6%, 95% CI: 10.1-20.6] compared to women who did not report disabilities [7.2%, 95% CI: 5.9-8.8].

With regard to the prevalence of IPV among ever-partnered women in the past 12 months, there were no significant differences between women with and women without disabilities. The prevalence of recent sexual violence and physical and /or sexual violence were higher among ever-partnered women with disabilities compared to women who did not report disabilities (Table 23). However, the prevalence of physical violence, emotional abuse and economic abuse by a partner were higher among ever-partnered women without disabilities compared to women with disabilities (weighted numbers are provided in Appendix K).

Table 23: Percentage of ever-partnered women, aged 18 years and older who reported ever experiencing any form of lifetime and recent intimate partner violence by disability status, South Africa, 2022

	Ever experienced intimate partner violence				Experience of intimate partner violence in the past 12 months			
	%	95% CI	n	p-value	%	95% CI	n	p-value
Total			5 151				5 151	
Physical violence				0.016				0.556
Disability – Yes	29.3	[23.4-36.0]	392		4.3	[2.2-8.3]	392	
Disability – No	21.7	[19.4-24.2]	3 405		5.3	[4.3-6.5]	3 405	
Sexual violence				<0.001				0.277
Disability – Yes	14.6	[10.1-20.6]	391		3.6	[1.8-7.3]	391	
Disability – No	7.2	[5.9-8.8]	3 398		2.4	[1.8-3.1]	3 398	
Physical and/or sexual violence				0.011				0.800
Disability – Yes	31.2	[25.2-38.0]	392		6.9	[4.0-11.5]	392	
Disability – No	23.2	[20.9-25.7]	3 407		6.4	[5.3-7.7]	3 407	
Emotional abuse				0.019				0.810
Disability – Yes	31.9	[25.7-38.7]	391		9.6	[6.4-14.2]	391	
Disability – No	24.4	[22.1-26.9]	3 409		10.1	[8.6-11.8]	3 409	
Economic abuse				0.146				0.974
Disability – Yes	16.3	[12.0-21.7]	392		4.4	[2.6-7.4]	392	
Disability – No	12.8	[10.9-14.9]	3 412		4.5	[3.5-5.7]	3 412	
Controlling behaviour				0.599				
Disability – Yes	60.0	[50.5-68.8]	291					
Disability – No	57.4	[54.1-60.6]	2 794					

3.15.5. Prevalence of non-partner violence among women with disabilities

The prevalence of non-partner lifetime physical, sexual and physical and/or sexual violence among women living with disabilities was higher; 28.2%, [95% CI: 23.0-34.1], 8.2% [95% CI: 5.7-11.5] and 31.7% [95% CI: 26.4-37.5], respectively, compared to their counterparts who did not report a disability; 24.3% [95% CI: 22.1-26.6], 5.7% [95% CI: 4.8-6.7], 26.6% [95% CI: 24.3-28.9], respectively; however, these differences were not statistically significant. Weighted numbers are provided in Appendix K.

With regard to the prevalence of non-partner violence among all women in the past 12 months, there were no significant differences between women with and women without disabilities. A higher proportion of women without disabilities reported experiencing physical violence [3.5%, 95% CI: 2.6-4.6], sexual violence [0.6%, 95% CI: 0.4-1.0] and physical and/or sexual violence [3.8%, 95% CI: 2.9-4.9] compared to women with disabilities [2.1%, 95% CI: 0.9-4.6], [0.3%, 95% CI: 0.0-1.9] and [2.1%, 95% CI: 0.9-4.6], respectively.

3.16. Prevalence of victimisation, perpetration of violence against other men and age at first forced sex of a woman

The study also sought to understand men's use of violence against other men, age of first forced of woman as well as men's own experiences of violence. In line with what is known about men's reporting and help-seeking behaviour for GBV,[76-78] there were relatively low proportions of men reporting perpetration of sexual violence towards a boy or man, or experiencing physical and sexual violence by men.

3.16.1. Prevalence of lifetime perpetration of sexual violence towards other men

Overall, 1.3% [95% CI: [0.9-2.0] of men reported that they had perpetrated sexual violence towards other men. Specifically, 0.9% [95% CI: 0.6-1.3] indicated they had ever done anything non-consensual and sexual with a boy or man, or coerced, forced or manipulated him. Similarly, 0.9% [95% CI: 0.5-1.4] reported they had ever done anything sexual with a boy or man by putting their penis in his mouth or anus without his consent or by force. Approximately 0.8% [95% CI: 0.5-1.3] of men reported that they and other men ever had sex with a man at the same time without his consent or by coercion, force or manipulation.

3.16.2. Prevalence of physical and sexual violence victimisation of adult men

Approximately 2.3% [95% CI: 1.7-3.2] of men indicated that a man had ever forced them to have sex or do something sexual. Overall there were 20.4% [95% CI: [18.4-22.6] of men who reported experiencing other forms of violence in the past 12 months outside the home; with 14.2% [95% CI: 12.6-16.0] of men reporting that they had been punched or hit, 13.5% [95% CI: 11.9-15.3] had been threatened with a knife or other weapon (excluding firearms), and 9.8% [95% CI: 8.3-11.5] indicated they had been threatened with a gun.

3.16.3. Prevalence of childhood abuse of men

Almost three quarters of men, 74.6% [95% CI: 72.2-76.7] reported a history of physical abuse before the age of 18, which translates to an estimated 14 558 519 men who suffered childhood physical abuse (Appendix J). Furthermore, 15.7% [95% CI: 13.9-17.7] of men reported a history of sexual abuse during their childhood (before age 18), which translates to an estimated 3 055 810 men who reported childhood sexual abuse (Appendix J).

3.16.4. Victimisation of men by women: physical intimate partner violence

Of women who were asked if they had ever hit or beaten their partner when he was not hitting or beating them, 7.8% [95% CI: 6.6-9.2] indicated that they had hit or beaten a partner. Men were not asked directly if they had experienced IPV.

3.16.5. Age at first perpetration of forced sex on a woman

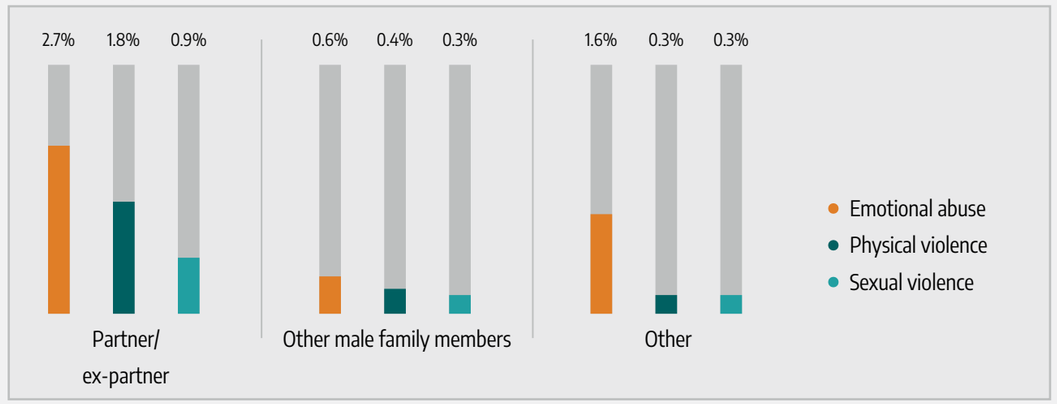
Men were asked what age they were the first time they had coerced, forced or manipulated a woman or girl to have sex or had non-consensual sex with a woman or girl. Of the n=184 men who answered this question, most indicated that they had never perpetrated forced sex (45.4%, 95% CI: 36.9-54.1) (Appendix C). However, a further 29.3% (95% CI: 21.6-38.5) of men indicated that they were between 15 and 19 years old the first time they perpetrated forced sex on a female. A further 21.4% (95% CI: 15.2-29.2) of men indicated they were between the age of 20 and 29 years of age the first time they perpetrated forced sex on a female.

3.17. Violence during the COVID-19 lockdown period

COVID-19 and the associated lockdowns lasted two years (approximately 750 days) in South Africa.[79] This period was said to have led to a spike in GBV cases.[80,81] This study explored women's experiences of GBV during lockdown. The study found that the reported proportion of women who experienced violence ranged from 0.3% to 2.7% during lockdown, with the perpetrators mostly being their partners (Figure 19).

Overall, 1.8% of women reported experiencing physical violence, 0.9% experienced sexual violence, and 2.7% experienced emotional abuse by their partner or ex-partner during the lockdown period. Few women reported violence or abuse by other male family members (0.3% – 0.6%), while 1.6% of women reported experiencing emotional abuse by other people.

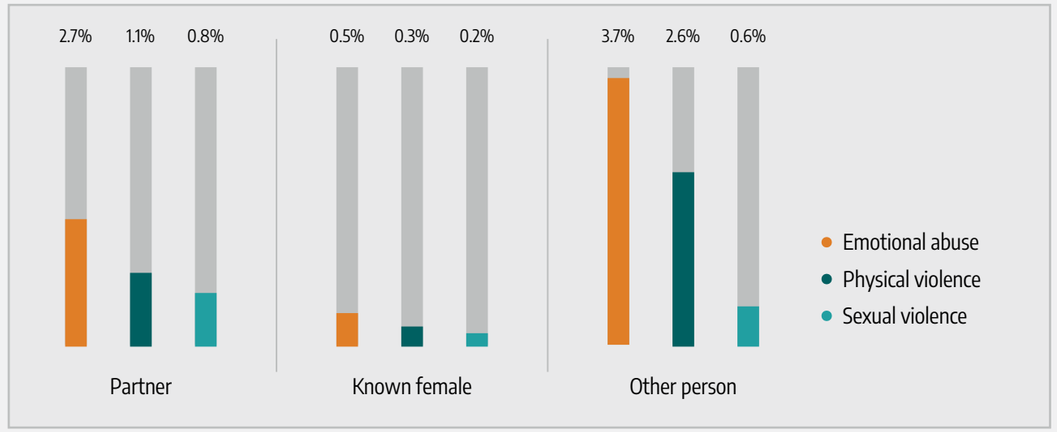
Figure 19: Percentage of all women aged 18 years and older who reported experiencing emotional, physical and sexual violence during COVID-19 lockdown by various perpetrators, South Africa, 2022



The study also sought to measure the prevalence of GBV perpetration among men during the COVID-19 lockdown periods. Although the reported proportion of male perpetration of violence ranged from 0.2% to 3.7% during lockdown, notably the victims were mostly their partners (Figure 20).

Overall, the proportion of males who perpetrated physical violence on another person was 2.6% with 1.1% of men physically abusing their partners during lockdown. Approximately 0.8% of men sexually abused their partners and 0.6% sexually abused another person during lockdown. Furthermore, 3.7% of men reported they had emotionally abused another person, while 1.9% reported that they emotionally abused their partner during the COVID-19 lockdown.

Figure 20: Percentage of all men aged 18 years and older who perpetrated emotional, physical and sexual violence during COVID-19 lockdown by victim identity, South Africa, 2022



3.18. Norms and attitudes towards gender-relations among women and men

3.18.1. Attitudes and perceived norms towards gender relations

Holding harmful gender norms and attitudes especially against women and other marginalised groups is one of the factors that has been associated with GBV and its perpetration. Respondents were presented with a series of statements on gender norms. They were then requested to indicate the extent to which they agreed or disagreed with the statements. More than half of ever-partnered women (59.6%) agreed that a woman's most important role is to take care of her home and cook for her family, followed by 53.8% who agreed that it is a woman's responsibility to avoid getting pregnant, 48.0% who agreed that men need sex more than women, and 30.3% who believed that a person needs to be tough to be a man (Figure 21). About 11.5% of ever-partnered women believed that a woman should tolerate violence in order to keep her family together and 12.0% believed that if someone insults a man, he should defend his reputation with force if he has to.

As seen in Figure 22, 66.6% of ever-partnered men believed that a woman's most important role is to take care of her home and cook for her family, followed by 54.4% who believed that men need to be tough and 51.6% believed that men need more sex than women. About 10.7% of ever-partnered men agreed that a woman should tolerate violence in order to keep her family together, 8.3% agreed that there are times when a woman deserves to be beaten and 30.6% agreed that if someone insults him, he should defend his reputation with force if he has to.

Figure 21: Percentage of ever-partnered women aged 18 years and older who agreed with the statements about gender relations between men and women, South Africa, 2022

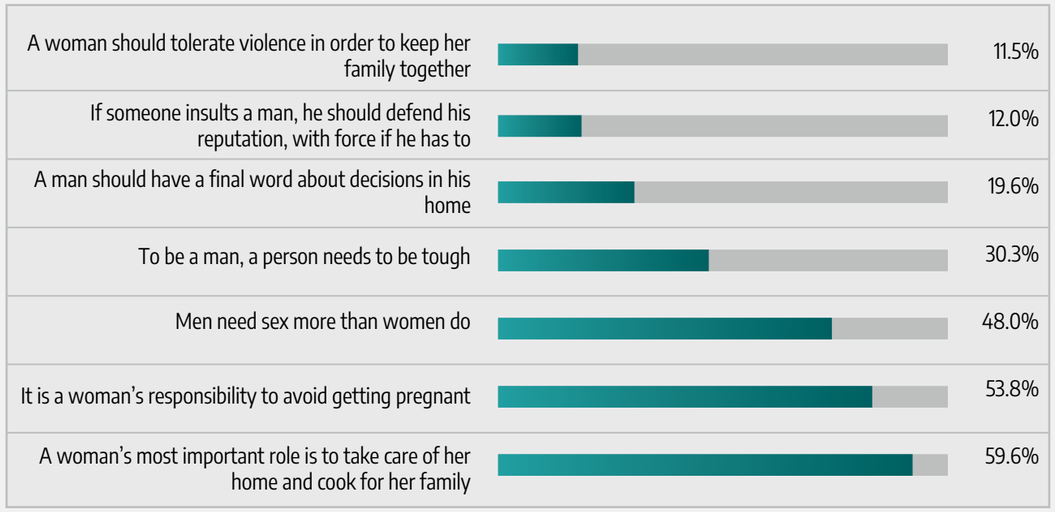
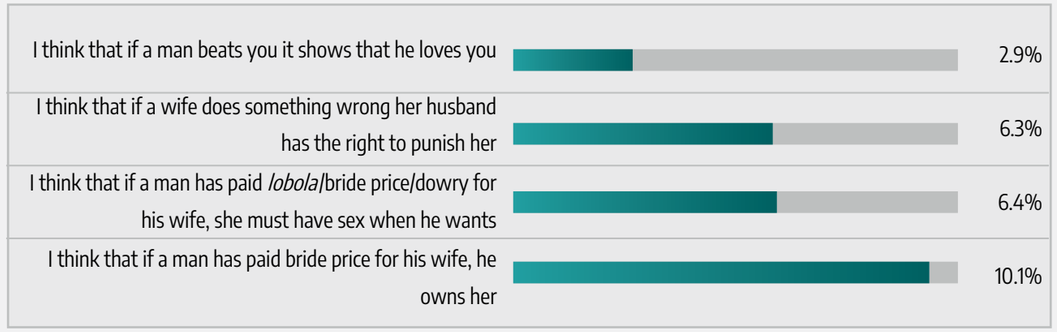


Figure 22: Percentage of ever-partnered men aged 18 years and older who agreed or strongly agreed with the statement about gender relations between men and women, South Africa, 2022

3.18.2. Attitudes and gendered power relations

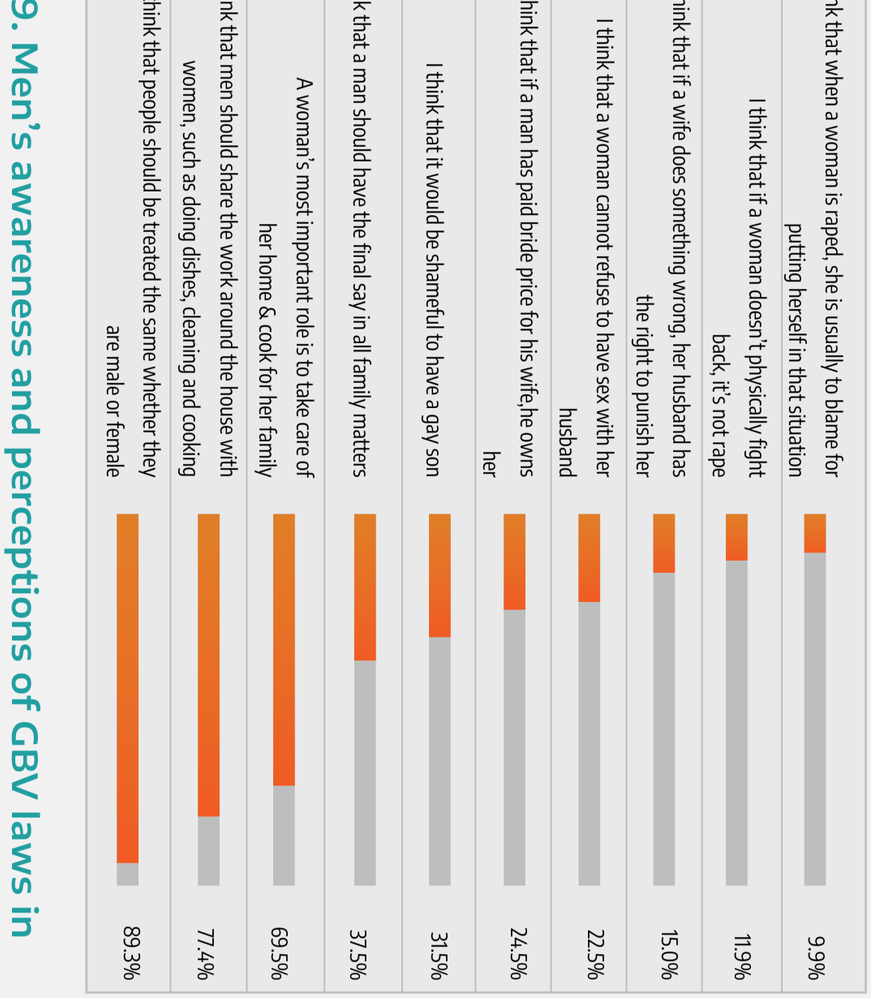
The study also explored attitudes and gendered power relations. This included ownership of women and associated cultural aspects such as *lobola* or the bride price. It was found that approximately 10.1% of ever-partnered women agreed that if a man has paid the bride price, he owns her, and 6.4% of ever-partnered women believed that if a man has paid *lobola*/bride price/ dowry for his wife, she must have sex with him whenever he wants, and 6.3% believed that a husband has the right to punish his wife if she does something wrong (Figure 23). Some ever-partnered women (2.9%) believed that if a man beats her, it shows that he loves her.

Figure 23: Percentage of ever-partnered women aged 18 years and older who agreed with the statements about gendered power relations and abuse between men and women, South Africa 2022



About gendered power relations, Figure 24 shows that 89.3% of ever-partnered men agreed people should be treated the same irrespective of their gender, 77.4% thought that men should share the work around the house with women, and 69.5% of men thought that a woman should obey her husband. Relatively lower proportions of ever-partnered men held the view that a man should have the final say in all family matters or that it would be shameful to have a gay son. Regarding ever-partnered men's views on rape, 9.9% held the view that when a woman is raped, she is usually to blame for putting herself in that situation. A further 11.9% of ever-partnered men agreed that if a woman does not physically fight back, it is not rape. The data also show that 15.0% of ever-partnered men agreed that if a wife does something wrong, her husband has a right to punish her. Furthermore, 22.5% of ever-partnered men agreed that a woman cannot refuse to have sex with her husband.

Figure 24: Percentage of ever-partnered men aged 18 years and older who agreed or strongly agreed with the gender statements about gendered power relations and abuse between men and women, South Africa 2022



3.19. Men's awareness and perceptions of GBV laws in South Africa

In recent years South Africa has strengthened laws pertaining to GBV. The majority of men (84.8%) [95% CI: 82.9-86.5] were aware that there were laws in South Africa about violence against women (Table 24). Awareness about these laws varied significantly by race, relationship status, highest education level, employment status, province, and locality type. The proportions of men who were aware of the presence of these laws were significantly higher among men who were currently married and men who had a partner and were not cohabiting than those who were not currently in a relationship. It was also significantly higher among men of other race groups compared to Black African men. Furthermore, awareness of these laws was significantly higher among men with tertiary education compared to those with primary school education, men who were employed compared to those who were unemployed and men in urban areas compared to those in rural informal areas.

Further, the majority of men (84.0%) [95% CI: 81.8-86.0], were aware that a husband who forces his wife to have sex against her will is committing a criminal act (Table 24). This awareness varied significantly by education level, employment status, and locality type. Men residing in urban areas had a significantly higher level of awareness that a husband who forces his wife to have sex against her will, will be committing a criminal act than men in rural informal areas. Overall, 73.9% [95% CI: 71.6-76.1] agreed with the statement that 'They make it too easy for a woman to bring a violence charge against a man.' The percentage who agreed with this statement was significantly higher among Black African men, men who had a partner but were not cohabiting, men with primary school as their highest education attainment level, and men in rural informal areas than men of other race groups, men who were married or not in a relationship, men with tertiary education, and men in urban areas, respectively.

Table 24: Men's (aged 18 years and older) awareness and perceptions of laws on gender-based violence by socio-demographic characteristics, South Africa, 2022

	Awareness of laws on gender-based violence				Perceptions of forced sex within marriage as a criminal act				Perception that it is too easy for a woman to bring a violence charge against a man							
									Strongly agree/agree		No opinion		Disagree/strongly disagree			
	%	95% CI	n	p-value	%	95% CI	n	p-value	%	95% CI	%	95% CI	%	95% CI	n	p-value
Total	84.8	[82.9-86.5]	4 295		84.0	[81.8-86.0]	4 310		73.9	[71.6-76.1]	10.4	[9.1-11.8]	15.7	[14.0-17.7]	4 327	
Age group				0.533				0.116								0.593
18–24	84.4	[80.4-87.8]	669		79.9	[75.0-84.0]	668		75.4	[70.0-80.1]	8.9	[6.2-12.6]	15.8	[11.8-20.7]	668	
25–34	85.5	[82.2-88.2]	1 076		85.6	[82.2-88.4]	1 076		75.2	[71.0-79.0]	10.1	[7.8-12.9]	14.7	[11.6-18.4]	1 086	
35–49	83.5	[80.0-86.5]	1 323		85.3	[81.8-88.2]	1 329		74.6	[70.7-78.1]	9.9	[7.5-12.9]	15.5	[12.7-18.8]	1 332	
50+	86.0	[83.0-88.5]	1 225		83.8	[80.6-86.5]	1 235		70.3	[66.3-74.1]	12.4	[9.9-15.5]	17.2	[14.1-20.9]	1 239	
Race				0.009				0.128								<0.001
Black African	83.4	[81.2-85.4]	3 468		83.1	[80.5-85.4]	3 483		79.1	[77.1-81.0]	8.4	[7.2-9.8]	12.4	[10.9-14.1]	3 497	
Other race	90.1	[86.5-92.8]	825		87.5	[83.4-90.7]	825		54.4	[48.0-60.6]	17.6	[13.8-22.2]	28.0	[22.5-34.3]	828	
Relationship status				<0.001				0.052								0.001
Currently married	88.1	[85.5-90.2]	1 370		86.8	[83.9-89.2]	1 377		69.4	[65.3-73.2]	12.4	[9.8-15.5]	18.2	[15.2-21.7]	1 385	
Cohabiting, not married	83.2	[77.8-87.5]	595		83.4	[76.2-88.8]	600		75.4	[70.5-79.8]	8.1	[5.8-11.3]	16.4	[12.7-21.0]	602	
Partner, not cohabiting	86.9	[84.4-89.1]	1 297		84.3	[80.4-87.5]	1 301		79.8	[76.6-82.7]	8.5	[6.6-10.8]	11.7	[9.5-14.3]	1 305	
No relationship	78.4	[74.4-81.9]	950		81.1	[77.4-84.4]	947		70.5	[65.2-75.3]	11.5	[8.7-14.9]	18.0	[14.0-22.9]	950	
Highest level of education				<0.001				0.044								0.005
No formal schooling	80.5	[67.5-89.2]	95		77.8	[64.9-86.9]	94		67.3	[52.3-79.5]	15.8	[7.6-29.8]	16.9	[8.6-30.6]	95	
Primary school	77.9	[72.0-82.9]	654		78.6	[73.2-83.2]	661		79.4	[74.5-83.5]	10.2	[7.5-13.9]	10.4	[7.6-14.1]	664	
Secondary school	84.8	[82.7-86.7]	2 830		84.7	[82.4-86.7]	2 843		74.7	[72.1-77.2]	9.7	[8.2-11.4]	15.6	[13.6-17.8]	2 849	
Tertiary	89.9	[86.2-92.7]	627		85.4	[79.9-89.6]	625		66.7	[61.0-72.0]	13.4	[9.8-18.0]	19.9	[15.5-25.0]	631	
Employment status				<0.001				0.047								0.371
Unemployed	80.2	[77.0-83.1]	1 677		82.1	[79.0-84.9]	1 679		75.5	[72.0-78.7]	10.0	[8.2-12.2]	14.5	[12.0-17.3]	1 689	
Employed	88.5	[86.7-90.0]	2 584		85.7	[83.0-88.0]	2 596		72.8	[69.9-75.5]	10.5	[8.8-12.5]	16.7	[14.4-19.3]	2 605	
Locality type				0.002				0.001								<0.001
Urban	87.1	[85.1-88.8]	2 664		86.8	[84.4-89.0]	2 665		71.1	[68.2-73.9]	10.7	[9.0-12.6]	18.2	[15.8-20.9]	2 678	
Rural informal (tribal areas)	80.0	[75.2-84.1]	909		78.0	[72.1-82.9]	913		81.1	[77.2-84.5]	8.6	[6.5-11.2]	10.3	[8.0-13.2]	919	
Rural formal (farms)	80.9	[74.1-86.2]	722		80.0	[73.0-85.5]	732		72.0	[65.7-77.6]	15.5	[11.5-20.6]	12.4	[8.5-17.9]	730	

CHAPTER 4

DISCUSSION

4.1. Introduction

This report presents the findings of the first fit-for-purpose national study on the prevalence of GBV in all nine provinces of South Africa. It outlines the prevalence of physical, sexual, emotional, economic, and psychological violence, such as controlling behaviour across all adult age groups. It also examines the perpetration of violence by men against their female partners and the underlying role of gender norms in driving GBV. The results provide empirical evidence and confirmation of the patterns of violence in the country and contribute to understanding the life course of victimisation and perpetration among adults in South Africa.

This report serves as a vital source of information for government, researchers, academics, civil society, developmental partners, policymakers, and practitioners. The current study is a step forward and adds to the body of knowledge about GBV in South Africa. The data collected are an important source for reporting and tracking progress in addressing GBV in South Africa, as outlined in the GBVF NSP. The study enables the country to report prevalence estimates that are comparable to other countries that have adopted the WHO's globally recognised approach for measuring GBV, in line with reporting requirements to the United Nations (UN), African Union (AU) and SADC Gender Desk.

This chapter highlights key insights from the study, discusses the prevalence of physical, sexual, emotional, and economic violence, followed by a comparison of our findings with previous South African, African and global surveys. A discussion of the drivers or associated factors for the victimisation and perpetration of GBV follows. These are bivariate associations; more rigorous analyses using multiple regression models will be performed in the future to fully assess these associations after adjusting for confounding variables. We conclude the section by discussing psychological violence, such as controlling behaviour, and the underlying role of gender norms in driving GBV.

4.2. Physical and sexual violence: victimisation of women

The study confirmed that GBV victimisation and perpetration are common in South Africa and that millions of women have been affected over their lifetime and in the twelve months prior to the study. Similar to what has been reported in other studies,[69] we found that lifetime and recent victimisation and perpetration of physical violence, at 33.1%, was higher than lifetime and recent victimisation and perpetration of sexual violence (9.8%) among all women regardless of partnered status. A similar pattern was observed with regard to lifetime IPV, with physical violence (22.4%) being higher than sexual violence (7.9%). We also found that the prevalence of lifetime non-partner physical violence was slightly higher (24.6%) than lifetime physical IPV (22.4%). Family members were the most frequently identified perpetrators of lifetime non-partnered physical violence, followed by acquaintances. Strangers were the least reported perpetrators of physical violence. These results challenge the traditional 'stranger-danger' narrative, which associate strangers with inherent danger and violence. The study confirms that women are physically violated most often by people they know.

In contrast to what we observed with regard to lifetime physical violence, lifetime sexual IPV (7.9%) was slightly higher than lifetime non-partnered sexual violence (5.9%). The estimates found in this study for lifetime non-partnered sexual violence are similar to the WHO and regional and global estimates for women aged 15 – 49 years (6.0%).[82] While our rates are the same as those reported previously, the low levels of disclosure of sexual violence observed in such studies could also be due to under-reporting. Trauma, fear of retaliation, stigma, shame, and not identifying forced sexual acts within a relationship as rape, have been cited as barriers to disclosure.[10,23,83] Nevertheless, this data is useful for identifying where prevention interventions and messaging should be focused.

Comparison with similar surveys (Appendix L) shows our lifetime IPV victimisation results are consistent with, but slightly higher than, those of the 2016 South Africa Demographic and Health Survey, which found that the prevalence of lifetime physical violence and sexual violence victimisation among ever-partnered women aged 18 years or older was 20.5% and 6.2%, respectively.[69] A comparison of data coming from the region shows that the results from SSA countries are varied. Some studies have reported a lower prevalence of both lifetime physical and sexual IPV, and others have reported a higher prevalence compared to South Africa. For example, the pooled prevalence estimate of physical IPV across 23 countries in SSA was 26%, ranging from 5.5% to 59.9%.[84] Other population-based studies in SSA have reported high levels of lifetime sexual violence among women, ranging from 4.3% to 76.4%.[23,84,85]

Our findings were compared with the 2018 prevalence estimates from the WHO on violence against women, which indicate that approximately one in three women globally (30%) have experienced physical and/or sexual violence at some point in their lives, either from an intimate partner or a non-partner. Notably, the majority of this violence is perpetrated by intimate partners, with nearly one-third (27%) of women aged 15 to 49 years who have been in a relationship reporting having been subjected to physical and/or sexual violence by their intimate partner. Our prevalence estimate was lower than the United Nations' global IPV victimisation prevalence of approximately one-third [19].

The WHO Africa Region prevalence estimate for lifetime physical and/or sexual IPV among partnered women aged 15 to 49 years was 33%, the global estimate was 27%, and the estimates for the past 12 months were 20% and 13%, respectively.[21] Our study found a prevalence of 23.9% for lifetime physical and/or sexual IPV among women aged 18 years and older. The prevalence of lifetime sexual violence by a non-partner was 5.9% which is similar to the regional and global estimate of 6%.[21,82] As mentioned previously, South Africa is considered to have one of the highest GBV rates in the world, with sexual violence being of particular concern. Our findings suggest that, while South Africa does have high rates of violence directed at women, it is not at the extreme spectrum of lifetime physical and/or sexual IPV perpetration and victimisation.

Our report found lifetime (9.8% translating to 2 150 342) and recent (2% translates to 432 525) sexual violence among all women. Sexual violence encompass acts of forced sex, including rape by a partner or a non-partner and sexual assault. South Africa may now have a national sexual violence prevalence statistic (for all women, IPV and non-partner violence) that is closer to the estimates that researchers, practitioners and activists have suspected. The recently released Governance, Public Safety and Justice Survey reported an increase in the number of victims of sexual offences from 30 000 in 2022/2023 to 52 000 in 2023/2024.[29] Available data from the Institute for Security Studies (ISS) for the period 2022/2023 found a total of 42 780 reported rape incidents.

These studies report statistics that are similar to the South African Police Services (SAPS). Over the years, many researchers, practitioners and activists have critiqued the SAPS data, indicating that there is an under-reporting of sexual violence (inclusive of rape and sexual assault) and because of this under-reporting and the lack of national prevalence data, some researchers have concluded that the rape statistics for South Africa is elusive.[86] Some of these issues pertain to non-disclosure and non-reporting of sexual offences, together with the difficulty of comparing GBV estimates from different data sources and countries. Another tension is that, over the past 25 years, different authors have cited the Human Rights Watch as the source for South Africa being dubbed the 'rape capital of the World'.[86-88] In the absence of national prevalence data, media reports and popular advocacy campaigns on GBV have often used the same language identifying South Africa as "the rape capital of the world" in their messaging. However, our survey estimates for lifetime non-partner sexual violence victimisation show rates that are similar to those reported globally and in the African region (6%).[21] In light of these results, South Africa does not have the highest prevalence of non-partner sexual violence in the world, instead available data suggest that some countries in different WHO regions have much higher non-partner sexual violence prevalence rates. Nevertheless, while the observed difference between regional estimates are real, the WHO recommends caution when comparing regional NPSV estimates due the varying measures, cultural contexts and under-reporting that exists across different countries.[21] These current estimates will contribute to the development of the Gender-Based Violence Index for South Africa.[89]

4.3. GBV among women with disabilities

According to the 2023 UNFPA report on disability and GBV, 18.0% of the global female population has a disability.[90] People with disabilities have a 1.5 times greater risk of experiencing violence than those without disabilities.[91] Furthermore, data from low- and middle-income countries show that women with disabilities are two to four times more likely for to experience IPV.[92] Similarly, this study found that women living with disabilities experienced higher rates of multiple forms of violence. More ever-partnered women with a disability had experienced physical violence (29.3% vs 21.7%), physical and/or sexual violence (31.2% vs 23.2%), emotional abuse (31.9% vs 24.4%), economic abuse (16.3% vs 12.8%), and controlling behaviour (60.0% vs 57.4 %) from a partner in their lifetime than women with no disability. The prevalence of sexual violence from a partner was twice as high (14.6% vs 7.2%) for ever-partnered women living with a disability than for those who did not report a disability. In addition, lifetime experiences of physical violence, sexual violence, and physical and/or sexual violence were all considerably higher for women living with a disability regardless of partnered status. Although the estimates in this study are lower than those found in some countries, they are indicative of the growing concern to include women with disabilities in GBV research and response.[90] Previous studies have shown that the various types of abuse experienced by women with disabilities include, but are not limited, to physical, sexual, economic, emotional, and structural abuse.[93] South Africa still has a scarcity of data on GBV experienced by women with disabilities at a national level.[92] This highlights the need to include this marginalised group of women in GBV research and programming.[90]

4.4. Physical and sexual IPV perpetration by men

We found that the prevalence of perpetration of lifetime physical IPV was 16.7%, and sexual IPV was 7.5%. These estimates are similar to the results for lifetime IPV victimisation. While the percentage of women reporting lifetime physical IPV victimisation was slightly higher than that of men reporting lifetime physical IPV perpetration, the figures are not drastically far apart (22.4% vs. 16.7%). This finding significantly validates the survey results regarding the ethical considerations included in survey design and operations. It also suggests that, despite the known under-reporting expected in such studies, the methodology appears to have made both women and men equally free to report. It is also encouraging to see that, despite the stigma, fear and possible distress associated with disclosing GBV victimisation and perpetration, both women and men were willing to talk about their experiences.

In general, the prevalence estimates of physical and sexual IPV perpetration found in this study fall within the range that has been reported in previous studies conducted in South Africa.[94-96] These studies reported male physical IPV perpetration prevalence of between 9.0% and 42.0%.[94-96] Nevertheless, the results of this study are lower than those reported in the UN men's study, in which the prevalence of lifetime physical violence and sexual violence perpetration against an intimate partner was 32.9% and 24.3%, respectively.[11,22] The observed inconsistencies in sexual violence perpetration rates across studies may be attributed to the differences in the populations studied and methodological approaches, including instruments used and study designs.

4.5. Childhood abuse and men's victimisation by female partners and other men

The men's questionnaire focused more on perpetration against women and men's use of violence against other men, but there was also a small section on victimisation, or their own experiences of violence. Some may argue that the approach adopted in the study implies a binary view of victimisation. This is not intended; rather, the approach is informed by evidence showing that the majority of perpetrators of GBV are predominantly men, and the victims are most frequently women and children.[97,98]

However, there is a limitation to this approach, so we foresee a need for future surveys to include a module on physical, emotional, together with other forms of non-physical violence experienced by and directed at male partners in both (women and men) instruments.[99] Data on IPV perpetration by women support this observation. Partnered women were asked if they had ever hit or beaten a partner when he was not hitting or beating them. We found that 7.8% of women had physically abused a partner, which translates to 1 073 329 women at a population level. Our results corroborate those of one systematic review, which reported pooled prevalence rates ranging between 3.4% and 20.3% for domestic physical violence against men.[100] The review also observed high rates of childhood abuse and maltreatment among men who were victims of domestic violence (10.6% to 40%).

In this study, we did not ask men directly about their experiences of IPV by a partner, but we did ask men about child abuse and found high levels of reported childhood trauma and experiences of being bullied, teased or harassed. The prevalence of physical and sexual abuse during childhood were high, with almost three-quarters of men reporting a history of physical abuse before the age of 18 and 15.7% reporting a history of sexual abuse. The reported history of childhood sexual abuse among men was higher than that observed for women (note difference in age cut off i.e. for women before age 15 and for men before age 18). Previous studies have found high rates of childhood physical and sexual abuse with some studies finding similar rates of reported sexual abuse and some finding higher rates for girls.[101,102] Evidence from a longitudinal study suggests that sexual abuse experienced by boys is generally underreported and not recognised as often, and sexually abused boys

rarely receive care and support.[55] There are also relatively fewer studies that have been conducted on sexual abuse of boys compared to girls, which contributes to inadequate knowledge and response.

The current study found that fewer men reported being victims or survivors of violence outside the home. These numbers may reflect non-disclosure, and the shame associated with reporting victimisation for men. Reporting of both IPV and non-partner violence by men is often met with disbelief, shaming, and humiliation.[100,103,104] Such stereotypes may prevent help-seeking and can perpetuate and even escalate violence in and outside of the family. Recognising female perpetrators and male survivors is important. Acknowledging that GBV is not exclusive to any gender is an important step toward providing adequate support for male victims of GBV, while also addressing female perpetrators of GBV.[105]

4.6. GBV during COVID-19 lockdowns

This study revealed lower-than-expected COVID-19 lockdown-related IPV victimisation and perpetration among ever-partnered women and ever-partnered men, respectively. While the evidence may not corroborate the widely reported surge in domestic violence at the onset of the pandemic,[114] particularly from high-income countries with stricter enforcement of lockdowns, this does not mean that GBV was not experienced or perpetrated. These findings should be understood as reflecting a specific point in time during which other factors that are not measured in the study were also at play (e.g., restricted movement, lockdown level, alcohol sale prohibitions, etc.). Therefore, these estimates should not be compared to recent or lifetime experiences of physical and sexual IPV.

The low rates found may also be due to the differences in methodological approaches, including instruments used for this component and study designs. However, the findings corroborate the fact that most of the violence experienced during the outbreak of the COVID-19 pandemic was perpetrated by intimate partners.[80,114,115]

4.7. Risks and drivers for victimisation and perpetration of GBV

Psychological, community and social risk factors interact with structural factors, such as gender norms and poverty, to drive GBV. Drivers or risk factors associated with IPV vary, with some of the factors overlapping for both male risks of perpetration of violence towards a partner and women's risk of being victimised by a partner.[36,116,117] In terms of drivers and associated factors for GBV, the findings confirm existing evidence. Similar to previous studies, this study found that the prevalence of women's victimisation and men's perpetration varies by socio-demographic factors and was higher among groups with certain socio-behavioural and psychological characteristics, and with childhood experiences of violence.[11,16,22,34,36,118] Victimisation and perpetration of different forms of GBV (physical, sexual, economic, emotional, psychological, such as controlling behaviour) varied by socio-demographic factors such as age, race, relationship status, and locality type. Furthermore, the findings suggest that age, gender, and race are essential in understanding GBV as it relates to gendered power dynamics in relationships.

The study found that Black African women are the most affected by both IPV and non-partnered violence. The results showed that, while GBV does not discriminate by race, a significantly higher proportion of Black African women had experienced both physical and sexual IPV and non-partnered physical and sexual violence than women of other race groups. The link between gender, race, social class, and GBV has been studied widely.[119] Violence affecting Black African women, Black women in general, and other marginalised groups should be contextualised using a historical- and intersectionality-informed approach, which would enable analysis of the combined impacts of gender relations, i.e., structural violence, behind these acts.[120]

Conceptualising GBV as both interpersonal and structural allows researchers to challenge the historical tendency in social, public health, and policy sciences 'to focus mainly on the individual and ignore broader determinants'[121] such as past injustices, racism, sexism, and social inequities in fueling victimisation and perpetration of GBV. Within the South African context, apartheid brutalised Black men and women and, in many ways, normalised violence.[36] The long-term effects of apartheid, racism, injustice, and intergenerational trauma continue to be experienced in society today, often manifesting as high levels of structural violence that are more common in Black communities.[36] These results also suggest a need for addressing GBV using a syndemic perspective. The syndemic framework is useful for explaining why certain individuals, families, or communities are more vulnerable (especially to violence in general and GBV in particular) than others.[122] This approach is supported by the evidence showing that victimisation and perpetration is higher among women and men who reported key socio-behavioural, psychological and childhood risk factors. GBV interventions need to factor in and address these underlying social and structural drivers.

Analysis by age showed that the prevalence of both victimisation and perpetration of all forms of IPV is higher in the younger age groups than among those aged 50 years and older. However, experiences of victimisation and acts of perpetration of IPV were found to start early and continue, spanning the whole life cycle, with 2.9% of all women over 50 years reporting experiencing physical and/or sexual violence in the past 12 months. Evidence elsewhere shows that the lifetime prevalence of IPV among older women ranges from 16.5% to 54.5%, but their age and life transitions mean that they may experience abuse differently from younger women.[123] Our findings are, therefore, consistent with other studies that have increasingly shown IPV over a life course, although many of these studies have found higher rates than this study.[123-125] The findings suggest that IPV victimisation and perpetration start early, pointing to a need for early interventions targeted at pre-adolescent girls and young women and adolescent boys and young men. These interventions need to be sustained throughout the life course.

One of the most important findings of the study is reaffirming the fact that growing up in households with IPV and/or domestic violence, and later perpetration and victimisation is linked to childhood experiences of physical, sexual, and emotional abuse. Violence is often socially learnt, and children mimic parents' and guardians' behaviour. Patterns of violence in communities are referred to as cycles

of violence because they tend to be intergenerational and persistent. Studies indicate that children who grow up in households where violence is prevalent are more likely to normalise violence in their relationships as adults.[116,126,127] Men who perpetrate IPV are more likely to have experienced physical abuse in their homes and have witnessed violence between their parents than men who do not perpetrate IPV.[128,129] Similarly, women reporting experiencing GBV are also more likely to have witnessed or experienced violence as a child.[36]

These observations have important implications for the long-term reduction and prevention of GBV. The evidence suggests a need for a holistic and multi-pronged approach to how cases of domestic violence and sexual assaults are reported to the family, health services, police or teachers. The findings suggest a need to give equal priority to the needs of the victims or survivors and the children who live in homes where there is domestic violence. This approach would entail extending the care and support to children and families who witness or are aware of the mothers and female figures in the family being abused within the household. Consequently, there is a need for early interventions aimed at healing the traumatic impact of witnessing or being exposed to domestic violence while addressing and preventing GBV during the life course.

The finding of higher IPV victimisation and perpetration among groups with socio-behavioural characteristics such as having multiple sexual partners, engaging in transactional sex, hazardous alcohol consumption, and drug use are not unique to this study.[130-132] Alcohol and substance abuse are well-documented risk factors for violence, and alcohol consumption is a driver of IPV[133-136] and non-partner violence.[137] In one study, a high proportion of men (67%) are reported to have consumed alcohol before physically abusing their partners.[134] Alcohol abuse affects communication and can lead to arguments that escalate and become physical.[137,138] It is important to note that, while alcohol is a known driver of IPV, there is also a reverse association between IPV and alcohol, meaning that a victim of IPV may use substances to cope with the abuse. Although causality is difficult to establish, research shows that IPV precedes alcohol and substance abuse in most cases.[139-141] With regards to socio-behavioural factors, this research also shows that risky sexual behaviour is likely to be a consequence of childhood abuse, as observed elsewhere.[142,143]

The study found high prevalence of poor mental health among men and a correlation between men's experiences of violence and bullying as children and the current perpetration of violence. A scoping review found that men are less likely to seek mental health care than women, and have higher rates of suicide.[144-146] The findings of the current study point to a crisis in men's mental health that impacts the perpetration of violence against women. We observed that the prevalence of IPV perpetration was higher in men who were currently at risk of clinical depression, who had lower scores on the life satisfaction scale, who reported ever having suicidal ideation, who had lower empathy scores, and had high scores on the childhood trauma scale. Similar findings have been reported elsewhere.[36,147-149] A history of childhood physical, sexual, and emotional violence, bullying others,

and/or being bullied were associated with IPV perpetration. These findings suggest a need for interventions that address childhood violence, masculinities, and poor mental health.

Previous studies have consistently shown that social and psychological factors are associated with male perpetration of IPV.[150-154] These include young age, low level of education, childhood trauma, abuse and neglect, harmful use of alcohol and drugs, personality disorders, acceptance of violence e.g., holding a belief that it is acceptable for a man to beat his partner.[150-154] For women, factors that have been associated with an increased risk of experiencing violence by partner(s) include low level of education, childhood sexual abuse, acceptance of violence, and prior exposure to other forms of abuse.[155] Similar risk factors are present in male perpetrators profiles and speak to broader community and social drivers of GBV.

The study found that household-based violence, including intimate partner violence and non-partner violence perpetrated by family members, was highly prevalent. In line with current findings, evidence shows violence against women is used as a means of addressing conflict in the home.[9] These observations suggest that families and households need to be one of the most important focal points for GBV interventions. These observations reiterate the need for developing integrated individual- and family-tailored, community-level GBV prevention interventions that are rooted in treating common mental health conditions and addressing bullying and the effects of childhood trauma. It is, therefore, important to promote programmes that focus on positive parenting and building family relationships. While the causal relationship between childhood maltreatment and experiences of violence later in life is unclear and needs more in-depth analysis, we acknowledge the important need for family and community-centred interventions for the prevention of childhood violence.

A unique finding in this study relates to the relationship between marital status, living arrangements and IPV. Generally, women and men who were cohabiting but not married had a higher prevalence of both victimisation and perpetration of all forms of GBV. The role of marital status and living arrangements needs to be studied further. This may indicate that marriage serves as a protective factor against some forms on GBV. While marriage and cohabitation have become rather similar over the years, one distinct difference is that marriage allows for investment in the quality of the relationship, couples are expected to share risks and devote more time to caring, educating, and assisting each other and raising children together.[156]

4.8. Emotional abuse

One of the strengths of this study is the inclusion of emotional and economic IPV. This data allows us to extend what we know about these two forms of IPV at a national level. The study also provides a baseline for tracking poly-victimisation of women and poly-perpetration of GBV by men in South Africa. The prevalence estimates of emotional abuse (25.1%) were slightly higher than physical violence (22.4%) for ever-partnered women. Previous studies (Appendix M), such as the UN men's study, showed that ever-partnered women reported a higher prevalence of emotional abuse (49.5%) than physical violence (35.2%).[11,22,106] However, the SADHS reported contradictory results in which women reported a higher prevalence of physical violence (20.5%) than emotional abuse (17.1%).[69] In terms of perpetration, the results of the current survey follow the same pattern as the UN men's report, which shows that the prevalence of emotional abuse perpetration is higher than that of physical violence perpetration (see Appendix M). It is important to recognise that emotional violence always accompanies physical violence in the IPV cycle of violence.

Among the insightful evidence from the study is the relationship between emotional abuse and education status. Studies have explored the relationship between women's education and experience of IPV. One study from Zambia found that women with a higher level of education than their spouses were more likely to experience different forms of domestic violence than those with a lower education or the same educational level as their husbands.[111] Similar findings were reported in Malawi.[112] In contrast, a study conducted in Nigeria found that women's education status was not significantly associated with emotional IPV.[113] Our study, similar to the Malawi and Zambia studies showed that women who had tertiary education and were employed were most affected by emotional abuse. This is useful data as it points to the pervasiveness of GBV. It also suggests that the education and employment of women alone are not protection against emotional abuse. The data instead points to a need to work with men because empowerment interventions that focus only on women may fail to address the pushback and emotional abuse that is often experienced by women who are perceived by a partner to be independent or self-sufficient. It also highlights the importance of interventions at the workplace and tertiary institutions.

4.9. Economic abuse

The findings of the current survey for the prevalence of economic abuse of ever-partnered women are lower than those reported in the WHO women's report (Appendix M). Similarly, the figures for the prevalence of perpetration of economic abuse by ever-partnered men (14.8%) were also lower in our study than in the UN men's report (34.0%) and other studies.[11,22] Our study did not find any significant difference between economic abuse and education status. Previous studies have found that people with a high school education experience higher rates of economic abuse than people with less than a high school education or with some university education.[107-109] In addition, the findings show that controlling behaviour as a form of psychological violence, as observed in other studies, is more common than physical or sexual violence (Appendix M).[110] Similar results were reported in the SADHS.[69]

An analysis of the gendered sources of income showed that 'money from own work' was reported by only a quarter of women, while this was the primary source of income for men. This indicates the extent of women's dependency on other sources of income for survival, which is a risk factor for controlling behaviour. These findings reaffirm that any form of economic violence is rooted in gender inequality and is reinforced by traditional gender norms that disproportionately affect women who are already marginalised.[16,157] Other studies concur with our findings, showing that South Africa is a highly patriarchal society with exaggerated racialised gender inequalities and the normative use of violence, especially against Black African women.[44]

4.10. Controlling behaviour, gendered norms, attitudes and gendered power relations

The use of power and control in relationships is often a precursor to increasingly psychologically abusive behaviour. The high levels of controlling behaviour reported by women younger than 50 years, Black African women, and those in non-marital relationships underscores the influence of age, race, and relationship status on power dynamics. The higher levels of controlling behaviour experienced by women younger than 50 years may be attributed to younger women being more likely to have partners who are older than them. These men tend to have the economic means to exert control. Age-disparate and intergenerational relationships are common in South Africa with power dynamics that increase the vulnerability of younger women to GBV.[158] The result may suggest that women over the age of 50 may have more economic stability than younger women and, therefore, experience less controlling behaviour from their intimate partners. Additionally, younger women are more likely to be economically dependent, have limited social networks, and be either in school or unemployed, which restricts their economic power. These findings highlight the importance of increasing women's decision-making autonomy, and increasing men's consciousness of psychological violence, such as controlling and manipulating behaviours.

The results on gender norms and attitudes indicated that almost 60% of women felt that a woman's most important role was to take care of the home and cook for the family, with over 50% of women indicating that it is a woman's responsibility to avoid getting pregnant. More than 60% of ever-partnered men believed that a woman's most important role was to take care of and cook for her family, while over 50% of men believed that men should be tough and that men need more sex than women. Regarding attitudes towards gendered power relations, a tenth of ever-partnered women agreed that if a man has paid bride price, then he owns her. However, the majority (89%) of ever-partnered men agreed that people should be treated the same irrespective of their gender.

These results indicate a need to explore women's investment in gender norms of femininity and masculinity. Women's viewpoints can reveal how gender norms, perceptions of femininity and expectations shape their experiences and responses to IPV, and understanding men's motivations and perceptions of masculinity provides insights into the factors driving abusive behaviours. Gender norms affect both men and women so addressing them in both – albeit in different ways – is key to improving gender relations and decreasing IPV prevalence. In countries where gender inequality is prominent in relationship and family structures, the risk of IPV is highest.[159] This is supported by a population-based sample of South African men that showed that the most violent behaviour was exhibited in men who expressed hypermasculine attitudes and behaviour.[160] By identifying and targeting risk factors, such as attitudes of ownership and entitlement, prevention policies and intervention programmes can be designed to transform harmful gender norms and attitudes. Interventions can include traditional community-based, gender-norm transformation training, engaging men, and empowering women.

4.11. Structural factors and impact of GBV

The study findings highlight the link between IPV and structural factors such as poverty. Studies show that food insecurity (which is an indicator of acute poverty) is associated with the experience of IPV among women in both low- and high-income settings.[22,161-163] In this study, higher rates of physical IPV perpetration were reported by men whose households experienced some food insecurity. Findings from the HSRC's National Food and Nutrition Security Survey and other studies in South Africa highlight that most households were mildly food insecure, with about one-fifth of households experiencing severe food insecurity.[164,165] Food-insecure households are more likely to be stressed about the distribution of food and other resources among household members, which may result in fighting. Impoverished households are also more likely to have difficulty in dealing with daily stressors, which can also result in fighting. Food plays an important role as it impacts individuals physiologically, so a lack of food may result in a decreased ability to regulate emotions, which may lead to conflict.[165,166] There is, therefore, a need to address food insecurity as a component of preventing GBV.

The high prevalence of reported injuries among women who ever experienced physical violence in this study reflects the significant impact of GBV, as observed in other studies.[167,168] However, most women who reported injuries due to violence highlighted that they did not require health care because of the injuries. The literature shows that under-reporting of injuries because of physical violence is linked to hesitancy to disclose violence.[169] Barriers to reporting include stigma, fear of retaliation, limited access to service providers, and impunity for perpetrators.[170] This underscores the urgent need to improve access to quality healthcare and support services for GBV survivors.

Furthermore, the findings reaffirm the need for strategies to prevent and respond to GBV and its consequences. These observations suggest a need for interventions that promote dialogues about GBV reporting to encourage help-seeking, increase utilisation of the available support services, and develop more discreet reporting methods (such as sealed self-report cards) to stop this scourge. Strengthening of existing services is needed at both hospital and police levels, and even at civil society level, as there is much evidence that these can discourage reporting. In addition, more research is needed to understand disparities in the prevalence of sexual violence, including the factors responsible for reporting higher or lower rates in different settings.

4.12. Awareness of GBV laws among men

In addition to partnered and non-partnered GBV, the study also explored awareness of GBV laws among men. The findings revealed that men's awareness and knowledge about the laws criminalising violence against women and associated sanctions were high. This is important because laws criminalising violence against women can play an important role in preventing such behaviour, ensuring the prosecution and punishment of perpetrators, empowering and supporting victims, and strengthening prevention.[171] However, despite high levels of awareness and knowledge, the perpetration of GBV is still high. This suggests a need to understand the gap between what men know and how some men behave.

While enforcement of the laws is important this should be coupled with other interventions that are aimed at preventing GBV. It was also noted that some beliefs reported by partnered men are problematic and include agreeing that a woman should tolerate violence in order to keep her family together, that there are times when a woman deserves to be beaten, and that if someone insults him, he should defend his reputation with force if necessary. Some of these beliefs indicate a defensive stance that could be linked to denial of abusive behaviours or a sense of impunity. For example, some men's belief about rape and the circumstance surrounding rape is concerning and suggest a tendency to blame the victim. Some men agreed with the statement that 'when a woman is raped, she is usually to blame for putting herself in that situation' (9.9%) and a further 11.9% agreed that 'if a woman does not physically fight back it is not rape'. Men who hold this belief are more likely to justify or downplay their abusive actions, contributing to a higher incidence of such behaviours.

Therefore, laws alone are not sufficient to change the norms and practices that normalise the use of violence against women.[80] Women should not only be encouraged to report GBV but should also be supported and protected from repercussions associated with reporting. Protection orders should be more easily and readily obtained and must be enforced by law enforcement officers. These protection and prevention services must be accompanied by social protection for women who remain financially dependent on their abusers. Changing social norms and individual attitudes that contribute to and normalise violence among the general public is vital. Religious, cultural, and educational institutions must be engaged to contribute to changing gendered and social perceptions.

The finding that neither educational level nor employment status was significantly associated with physical violence perpetration by ever-partnered men in South Africa suggests that factors beyond individual socio-economic status, such as societal attitudes toward gender roles, historical inequalities, and systemic power imbalances, may play a significant role in perpetuating physical violence. Men with secondary school education, however, reported higher sexual violence perpetration than men with only primary school education. This highlights the need for recognising that, while education and employment can provide individuals with opportunities and resources, they do not inherently change underlying beliefs and behaviours related to gender and power dynamics. We also acknowledge that other significant risk factors, such as alcohol use, poor mental health, and childhood trauma, often related to living in poverty, have an impact beyond the educational level or employment status. Another interesting finding is that men received money from their parents (as the second highest source of income). This points to a need for exploration of men's financial dependency in further research.

Finally, the findings reaffirm that any form of violence is rooted in gender inequality and is reinforced by traditional gender norms that disproportionately affect women who are already marginalised.[172,173] Future intervention studies should explore the intersection of multiple forms of violence to understand the progression, severity, and multiple overlapping factors that lead to poly-victimisation.

CHAPTER 5

CONCLUDING REMARKS

5.1. Conclusion

The survey findings reveal a troubling picture of GBV in South Africa, highlighting its widespread and severe nature. It highlights that a substantial proportion of women aged 18 years and older have experienced physical violence at some point in their lives, with significant differences based on race and relationship status. Sexual violence is also a major concern, having affected nearly one in ten women across the country. The study highlights that different forms of violence often start early, affecting pre-adolescent girls and boys, young women and men, as well as adults. The prevalence of recent victimisation and perpetration of violence among adults 50 years and older underscores the importance of a life course approach to preventing GBV. The study confirmed that exposure to childhood trauma plays a pivotal role in both victimisation of women and perpetration by men, and that women exposed to domestic violence as children had a higher prevalence of victimisation. The high rates of violence experienced by women, with even higher rates experienced by women with a disability, underscores the need for government, professionals and service providers to play a crucial role in identifying women affected by GBV and to ensure that youth and women with disabilities are included in prevention plans. There is also an urgent need to address the actions of men who perpetrate such violence, as well as the factors driving these behaviours. The study results reflect the pervasive issue of male perpetration, indicating that the violence women endure is a direct consequence of the actions of some men.

IPV was found to be notably high, with a considerable number of ever-partnered women reporting lifetime physical violence from a partner. This was found to be particularly prevalent among women who were cohabiting but not married. Also, a significant number of men reported having perpetrated physical or sexual IPV in their lifetime, with higher rates observed among men residing in urban areas. Findings on recent experiences of IPV show that a notable proportion of women experienced physical IPV, and a significant proportion experienced sexual IPV. Non-partner physical violence was found to be high, especially among younger and Black African women. Key factors that were found to be linked to higher IPV among women included the number of lifetime sexual partners, substance abuse, poor mental health, childhood trauma, and inequitable gender norms. For men, factors influencing IPV perpetration include hazardous alcohol consumption, having engaged in transactional sex, poor mental health, childhood trauma, and inequitable attitudes toward gender relations, with food insecurity also playing a role.

These persistently high rates of GBV victimisation and perpetration, despite existing legislative frameworks and policies, suggest the need for a comprehensive approach that not only addresses the immediate instances of violence but also includes a focus on women with disabilities and tackles the underlying structural and systemic factors. Addressing cultural and legal dimensions is essential for fostering a just and equitable society in which gender norms do not perpetuate violence and inequality. The high rates of GBV experienced by Black African women especially point to a need to work on relationship dynamics and violence within partnerships to tackle the historical trauma and social injustices that continue to affect Black communities. Decolonising GBV in South Africa, through a multifaceted approach that addresses the deeply entrenched colonial legacies influencing societal attitudes and systemic structures is important. Alternative decolonial models of GBV prevention that situate both women and men in community-centred interventions that focus on rebuilding the spirit of *ubuntu* as a catalyst for healing, protection and social justice are needed.

About a quarter of women reported experiencing emotional abuse in their lifetimes, while over a third of men admitted to perpetrating it. Economic abuse was also widespread, affecting a significant number of women. In addition, more than half of women reported experiencing controlling behaviour from partners, and a substantial proportion of men, particularly younger and Black African men, reported engaging in such behaviour. The data reveals deeply ingrained gender norms and power dynamics, with strong cultural reinforcement of traditional gender roles and a troubling acceptance of male aggression and dominance. Disturbingly, some men justified violence in certain circumstances and perceive laws as overly lenient toward women. This highlights a clear disconnect between legal knowledge of, and attitudes toward, gender-based violence.

These findings underscore the urgent need to tackle the rooted social and cultural factors that drive GBV and to bolster support systems for survivors. Strengthening policymaking and community interventions is essential for effectively addressing GBV. Future research should further explore the complexities of GBV to develop more effective prevention and intervention strategies. It is also important to recognise that individuals who have experienced or witnessed violence and abuse may be more likely to replicate these behaviours, with historical and intergenerational trauma playing a significant role in shaping such patterns. This report concludes by acknowledging the significant progress and innovation achieved by the government, civil society organisations, implementers, academics, researchers, and funders in addressing the GBV epidemic in South Africa. Moving forward, it is crucial to emphasise that continued collaboration and partnerships across all sectors is vital for effectively combating GBV and ensuring sustained progress.

5.2. Strengths of the study and innovation

This population-based household survey used a multi-stage stratified cluster random survey design which is an internationally recognised methodology for household-based surveys. This methodology has been implemented both locally and internationally. Having previously implemented several national prevalence surveys, the HSRC is regarded as one of the lead institutions in its implementation, not only in South Africa but globally.

The survey instruments that were used in this study have been developed and refined over decades by researchers at WHO, UNFPA, UN Women, SAMRC, Gender Links, and SADC Gender Desk working with different collaborators. The questionnaire was first pilot-tested and adapted for the South African setting.

The two instruments used (the WHO Multi-Country Study on Women's Health and Life Experiences questionnaire, and the United Nations Multi-Country Study on Men and Violence questionnaire) ensure that the data generated in South Africa is comparable to other GBV prevalence estimates in the African region and globally.

Although the final sample size fell short of the target due to the limitations outlined, the strength of the study is that the sample was weighted and benchmarked against the 2022 mid-year population estimates for adults aged 18 and older. This process ensured that the sample distribution closely matched the population distribution, affirming the survey's representativeness and its suitability for its intended purpose.

The realised sample was weighted to address potential unequal sampling probabilities inherent in the multi-stage stratified cluster random sampling design. It was further benchmarked against 2022 mid-year population estimates for adults aged ≥18 years, ensuring that the sample was generalisable to the total adult population of South Africa.

The study builds upon previous studies by incorporating expanded typologies of violence, including emotional, economic and psychological forms of victimisation and perpetration. The study measured many facets of victimisation, encompassing physical, sexual, and emotional violence as well as economic victimisation. By including data from men, the study provided insights from both the victim's and perpetrator's perspectives.

The study adhered to rigorous ethical and safety standards for research on violence against women. The data collection team consisted of well-trained individuals experienced in collecting sensitive data. Data collectors received support to manage the emotional impact of conducting such research.

The study is notably broader in scope and included both women and men over 50 years of age, unlike other studies that restrict participants to the 15 to 49-year age range.

5.3. Limitations of the study

Our study has limitations typical of large-scale surveys that should be considered when interpreting the results. While the low household response rates were a limitation, the individual response rates were high in cases where permission was granted to complete the questionnaire in the household.

Evidence suggest that low household response rates may be due to the general reluctance of the public to participate in intrusive in-person data collection during household screening, as well as fear of potential stigma and backlash related to reporting domestic violence.[174,175,176] In this survey, household responses may have been further affected by the timing of the survey, which was implemented shortly after the COVID-19 pandemic. This period introduced pandemic-specific operational challenges, such as restrictions that limited face-to-face interviews as observed in other studies.[177,178] Additionally, there has been a shift in the public's willingness to participate in household surveys post COVID-19, which is reflected in the high undercount in the 2022 South African Population Census.[179]

It has been shown that exposure to multiple surveys in a single year can significantly suppress survey responses.[180] The timing of the current survey coincided with multiple large-scale surveys whose implementation had also been delayed due to the COVID-19 lockdown. This included two nationwide studies conducted by the HSRC (the National Food and Nutrition Security Survey and the Population-based HIV Survey) as well as the Population Census 2022 conducted by Statistics South Africa. While the census was conducted nationwide, the HSRC assigned three distinct sampling frames to each of its surveys. This was done to minimise overlap of sampled SALs, to reduce respondent fatigue and to streamline data collection. Despite these measures, contamination of SALs through social media platforms still occurred. For example, fake news and misinformation on social media gained traction across the country leading to negative publicity against all HSRC studies.

In some neighbourhoods, particularly those with high levels of crime, the general social environment may have reduced the likelihood of potential respondents cooperating with data collectors. In some instances, data collection was not feasible due to safety risks, with some communities refusing data collectors access to SALs and households unless community members were employed as data collectors. These demands could not be accommodated due to concerns about compromising confidentiality and further reducing study participation.

Another contributing factor to low household response rates may have been the failure to locate individuals aged 18 years and older in selected households, despite repeated visits. People present in the home during the day were often the elderly, retired, or unemployed. The lower household response rates, especially in men's SALs, likely reflect the more frequent and longer absence of men from the household, due to employment and other lifestyle factors.

While the study may be limited by non-response bias due to unit or item non-response rates,[181,182] the weighting of the data minimised non-response bias. Moreover, all data collection was conducted by appropriately trained field staff and incorporated quality assurance measures, including fieldwork reviews by senior staff, computer-based data checks to monitor response rates and data quality, and steps to improve data collection.[183] Despite these measures, it is likely that the highly sensitive nature of the study contributed to households' declining participation despite the implementation of privacy and safety protocols during household entry and screening.

Differences in fieldwork efforts and field team performances may have impacted response rates.[177,178] In addition, the gap between the first and last interviews, which was caused by a data collection hiatus for several months, may have affected participation. The final phase of the survey occurred about a year after the peak of the COVID-19 pandemic.

The original targeted sample size was calculated based on available national DHS statistics on violence against women. Although, the anticipated sample size was not realised, the sample was benchmarked to the 2022 STATS SA mid-year population estimates, allowing for generalised national conclusions about the extent of GBV in the country. However, the study may be limited by the fact that all the data are self-reported, which is subject to both recall and social desirability biases that can lead to under-reporting. The cross-sectional nature of the study design also makes it impossible to infer causality from the findings.

Respondent-driven sampling (RDS) was adopted as a supplementary sampling method, aimed to enhance inclusivity by reaching individuals with disabilities and those from the LGBTQIA+ community. However, the household settings for recruitment proved less effective. RDS is generally well-suited for engaging marginalised groups through their peer networks in locations selected for privacy, acceptability, and convenience. Consequently, the attempt to use RDS in the household environment was unsuccessful and presented challenges that hindered the recruitment process, limiting the representativeness and generalisability of the findings. Due to these challenges, this component was discontinued. A separate paper will be prepared to outline the findings and the lessons learned to inform future studies.

Despite these limitations, the survey provides empirical evidence of the prevalence, pattern, and factors underlying victimisation and perpetration of GBV in South Africa. The data is essential for preventing and responding to GBV effectively and appropriately. Therefore, this first fit-for-purpose GBV national baseline survey is a critical step toward developing improved, more responsive, and appropriate policies and programmes to address GBV in the country. Experience has taught us that future surveys will capitalise on the insights and methodologies of the first national survey, and it is expected that the research will become increasingly robust with every series.

5.4. Lessons learnt

This section of the report highlights key insights from the research findings, providing valuable guidance for refining future research on this topic. One key lesson was that while sampling, questionnaire design, and methodological features are important, the quality of survey implementation plays a crucial role in the survey's success. In this survey, implementation involved the systematic use of data management systems to monitor fieldwork progress and data quality in real time through high-frequency reports on critical indicators to identify bottlenecks and poor performance, aimed at immediate corrective measures.

It is also important to note that, while planning is important, flexibility is key, and the team's willingness to adapt to changing situations, contextual factors, and time shifts is crucial. For example, extending survey hours to include evenings and weekends when employed people were more likely to be available helped to improve response rates in selected clusters. The safety of respondents and the research team is paramount when scheduling fieldwork and critical to ensure the successful completion of the survey.

Ensuring that all research team members were carefully selected, received extensive training, and received ongoing support for gathering sensitive information was a key factor for the successful implementation of fieldwork. Given the sensitive nature of the research, it was important that field staff manage difficult situations that could adversely affect them. It was also important to ensure gender equity in the formation of the data collection teams.[183] This involved including women and men from various age groups and gender identities. This helped address power dynamics and created a more comfortable environment for some participants, such as younger women who might feel safer discussing issues with their peers.[184,185]

Discussing GBV in the home environment may put participants at risk of further violence if the perpetrator is present or becomes aware of the interview. Finding a private space in the household to conduct the interview may have been challenging in some households, compromising the ability of participants to disclose information. In previous health surveys, the HSRC has piloted the use of mobile clinics to provide a private space, especially in high-density areas. However, this intervention has its own disadvantages, which include the cost of moving these mobile clinics around the country, safety when parked in the community, and possible stigma due to the attention the vans attract to selected households. Nevertheless, ensuring a private space for interviews within the household is critical, as it allows participants to disclose sensitive information safely and comfortably.

Studies should standardise questions about background characteristics and outcome measures for all key variables for both men and women's questionnaires. This should include consistent conceptualisation and coding of variables for ease of comparison. In this study, the men's questionnaire focused on the perpetration of violence against women and violence between men, with a small section on victimisation (their own experiences of violence). This approach may imply a binary view of victimisation, which is a limitation. Future surveys should extend both questionnaires to include modules on physical and emotional violence, as well as other forms of non-physical violence experienced by, and directed at, male partners in instruments targeted at both women and men. Adaptation of the questionnaire needs to be done carefully by balancing data needs with potential implications, such as the time required to train field staff, the time required to complete questionnaires, survey fatigue, and the total number of working hours required for data collection.

Finally, there is a need to explore innovative methodological approaches to enhancing the participation of marginalised communities, including LGBTQIA+ individuals and persons with disabilities, in nationally representative GBV population-based surveys. For example, adapting the RDS strategy specifically for urban SALs and where relevant NGOs operate could improve response rates and the success of this method. Future studies should also consider combining quantitative and qualitative research methods to gain a more nuanced understanding of the underlying causes and consequences of GBV.

CHAPTER 6

RECOMMENDATIONS AND POLICY IMPLICATIONS

6.1. Introduction

The findings of this study provide insights into GBV and highlight the necessity for developing targeted and comprehensive strategies to address GBV in South Africa. It also provides an opportunity to recalibrate the GBVF response, identify gaps and strengthen existing interventions that are outlined under the work of different pillars within the National Strategic Plan on GBVF (NSP on GBVF). The results of the study should be anchored within the NSP on GBVF with each government department and its stakeholders using the findings to take stock of where we are as a country with regard to the work outlined in the plan.

The current recommendations should be supplemented with carefully crafted evidence-based plans of action that are clearly owned by lead government departments and stakeholders who must be tasked with the role of implementing the recommendations. We propose that the Presidency, working with the Department of Women, Youth, and Persons with Disabilities (DWYPD) and Civil Society, be tasked with the role of leading this process. Each department should be tasked with developing a set of agreed-upon, actionable, costed, evidence-based action plans that are informed by the study results.

The recommendations are framed using the WHO's RESPECT framework[1] for GBV Prevention, which provides a comprehensive guideline for designing appropriate interventions that can address all levels of the socio-ecological model (societal, communal, interpersonal and individual levels). We also drew from the UN's Essential services package for women and girls subjected to violence, which prescribes international standards based on global evidence about what works best to address violence against women and girls (VAWG). Lastly, we consulted GBV experts who peer-reviewed the report to also review the recommendations with an aim of identifying gaps and strengthening them.

We recommend that interventions be implemented at individual, interpersonal, community, and societal levels. This approach can help to address the complex nature of GBV and improve prevention efforts across society. A collaborative approach involving various stakeholders, including government departments and other organisations, is crucial for effective implementation (see Appendix D).

Critical stakeholders for addressing the recommendations coming from this study include the Presidency, the future GBVF Council, the Department of Women, Youth and Persons with Disabilities, all other relevant government departments, and different spheres of government:

- **social, health and mental health services** to coordinate support services and focus on enhancing interventions for substance use, mental health, and gender-affirming care.
- **child protection and family support** to focus on early detection of childhood exposure to violence, provide family support programmes, and address intergenerational trauma.
- **educational and community-based interventions** to advance gender equality education, promote healthy relationships, and conduct community education workshops.
- **legal and law enforcement services** to work on enforcing domestic violence laws and strengthening legal frameworks.
- **research and policy development** to develop social policies, design long-term strategies to address and develop intersectionality-informed and culturally relevant interventions, and design comprehensive approaches for GBV prevention.
- **economic cluster, treasury, donors and developmental partners** to support the intersectionality-informed sector and community-based interventions that are required to address GBV and reduce incidence, and to support prevention programmes, including care and support services and GBV research across the country.

1. The frame work is grounded in global evidence and recommends seven strategies that are summarised in the acronym RESPECT: 1) Relationship skills strengthened; 2) Empowerment of women; 3) Services ensured 4) Poverty reduced; 5) Environments made safe; 6) Child and adolescent abuse prevented and 7) Transformed attitudes, beliefs, and norms.

6.2. Individual-level interventions

The study found that associated risks for victimisation and perpetration of IPV included mental health challenges, (particularly among men), lack of condom use, number of lifetime sexual partners, substance use, food insecurity, and childhood trauma, which includes witnessing domestic violence and for men being bullied or bullying others. The study also points to a crisis of mental health especially among men.

Suggested interventions include:

Addressing psychological and socio-behavioural factors:

- In light of the observed mental health crisis among men that impacts the perpetration of violence against women and the long-term impact GBV has on men and women's mental health, we recommend that the Department of Health urgently undertakes a review of the mental health services available, with the view to strengthening services, particularly for survivors of GBV, children who have witnessed GBV, and men.
- Integrate SRH&R services with GBV services to strengthen early detection of GBV cases and the implementation of risk reduction interventions aimed at curbing associated risky sexual behaviours, STIs, and substance use.

Implementing early learning and prevention initiatives:

- Interventions and programmes to prevent child abuse should include boys and girls. Implement early detection and empathetic responses to childhood experience of violence and bullying as a means to prevent perpetration of GBV later in life. Services for child survivors should be made equally accessible to boys and girls. This requires an investment in responsive and child-friendly protection systems and services that are more easily accessible to children and their caregivers.
- Implement robust child rights-focused programmes in schools to ensure that children who are victims of sexual abuse understand that their experiences are unacceptable. This programme should educate children about their rights, provide clear information on where to seek support, and assure children that the assistance they receive will be accessible, dependable and confidential.
- Create and integrate age-specific, evidence-based anti-violence programmes and training for children, youth, persons with disabilities, and adults to address high rates of GBV with a special focus on, child abuse, bullying, physical and sexual violence, emotional and economic abuse, and controlling behaviour.
- Develop evidence-based interventions aimed at shifting perceptions and promote gender equality by developing comprehensive learning programmes among young and older individuals on gender equality, the importance of mutual consent, and building healthy relationships that are pleasurable for both parties.
- Given the findings on harmful beliefs, controlling behaviour, and gendered power dynamics affecting both men and women, we recommend developing a comprehensive, age-appropriate government communication strategy. This strategy should aim to challenge and change these beliefs and norms by addressing socialisation processes and promoting unlearning and re-learning.

6.3. Interpersonal-level interventions

The study found that women were more dependent on grants as a main source of income while men were more likely to be employed, and their salary or wages was reported as the main source of income. This underscores the extent that women's dependency on other sources of income for survival is likely to be a risk factor for economic abuse and controlling behaviour. The study found that most of the physical violence that is perpetrated by a non-partner happens in the family or is perpetrated by a family member.

Suggested interventions include:

Economic empowerment and support through:

- implementing gender-transformative and economic empowerment interventions to improve the economic status and stability of women and their families, and addressing economic abuse by implementing interventions that are aimed at enhancing the overall livelihoods of both men and women, with a special focus on youth and women with disabilities.

Strengthening family interventions by:

- increasing investment in evidence-based family support programmes to prevent and address violence and tolerance for violence within the home environment.
- advocating for enforcement of domestic violence laws to protect victims/ survivors and expedite legal processes for granting of protection orders (including safe houses and shelters for women and children).
- ensuring that the law and GBV services are accessible to all women, especially youth and women with disabilities.
- expanding evidence-based family-strengthening interventions that address intergenerational trauma, child welfare, family safety, incorporating positive parenting and other evidence-based family-strengthening interventions that address intergenerational trauma, child welfare, family safety, incorporating positive parenting and other evidence-based strategies to heal the family.

6.4. Community-level interventions

The study found a strong correlation between holding inequitable gender norms and the perpetration of intimate partner violence (IPV).

Suggested interventions include:

Transforming gender norms and attitudes by:

- designing and implementing evidence-based, culturally relevant, community-based, tailored interventions focussed on changing harmful gender norms and attitudes (un-learning and re-learning).
- using community activism to change harmful gendered power relations and stereotypes through evidence-informed community-based interventions that educate youth, men and women about healthy, consensual relationships.
- emphasising the importance of healing from childhood trauma, mental health and seeking care.
- investing in evidence-informed programmes that promote gender-equitable relationships and transforming traditional gender roles.
- developing an evidence-informed government-wide communication strategy to shift harmful societal beliefs and norms regarding gender and GBV.
- training and engaging community leaders to transform societal attitudes that normalise psychological, economic and emotional abuse and work with communities to advocate for policies that highlight its seriousness, ensuring it is integrated into existing domestic violence frameworks.

6.5. Societal-level interventions

The study found that the most sought-after service after experiencing GBV was law enforcement followed by hospitals or health centres. Most women disclosed to their families and some to religious leaders.

Suggested interventions include:

improving support services and coordination by:

- enhancing coordination of information (shared data) and referrals among police, justice, social, and health services to provide comprehensive support for GBV victims/survivors, child witnesses, survivors with disabilities, and families and link perpetrators to appropriate interventions to address GBV perpetration.
- increasing access to quality GBV services for those who are not able to access one-stop care centres like Thuthuzela Care Centres.
- investment in existing service providers to widely and systematically increase their capacity to deal with GBV by adopting clear referral pathways and information sharing protocols – this can make a bigger stride for all victims/survivors, especially those with disabilities and those in hard-to-reach areas of the country.
- ensuring privacy and safety during routine health screenings especially for women with disabilities, offering gender-affirming care, and delivering high-quality mental health services tailored to survivors' needs.
- collaborating with local women's rights organisations, families and GBV-sensitised religious organisations to support victims/survivors and ensure they receive the necessary assistance.

Despite heightened awareness of GBV laws among men, the reported rates of perpetration suggest a gap between what some men know and practice. Therefore, additional interventions could include:

Enhancing the monitoring and assessment of GBV laws by:

- strengthening mechanisms for holding GBV perpetrators accountable and ensuring that these accountability mechanisms are not only punitive but are also designed to achieve changes in attitude and behaviour, rehabilitation, and healing.
- engaging national and civil society stakeholders to conduct impact assessments of GBV laws to identify implementation gaps.
- increasing collaboration with both formal and traditional legal systems to overcome barriers to the effective implementation and enforcement of GBV laws.

6.6. A call for long-term and holistic approaches

The high level of victimisation and perpetration of GBV observed among Black communities requires that key stakeholders tackle the difficult conversation about the historical impact of state-sponsored violence and the brutality of apartheid in our communities. The study highlights the complexity of GBV and the need for interventions that use an intersectional approach to address the colonial, relational and structural aspects of GBV. This must include addressing intergenerational trauma, effects of racism, and social injustices.

Given the scale of the challenge, it is important to harness existing capacity, while also building capacity to work towards eradicating GBV. Pillar 2 of the NSP on GBVF suggests capacity building through engagement with community development workers and community health care workers. These ideas for localising and extending the reach of prevention interventions should be piloted as part of the response. The NSP on GBVF also recommends that implementation of GBV prevention be integrated into programmes that address related social issues – specifically alcohol abuse, HIV prevention, and economic empowerment of women, youth, persons with disabilities and LGBTQIA+ individuals.

Suggested interventions include:

Government and research strategies to eradicate GBV:

- adopting a long-term, culturally relevant approach to GBV eradication, focusing on household, family and community environments.
- focusing on the different leadership layers in communities, particularly traditional communities, and linking GBV messaging to rebuilding social fabric, strengthening community and families, and raising young people that can actively reshape communities, families and society at large.
- developing appropriate social policies to address the social and structural drivers that were identified in the study.
- designing and evaluating interventions from an intersectionality-informed approach and culturally appropriate perspective, addressing the historical violence and disempowerment of women and Black communities in general
- commissioning organisations such as the Healing of the Memories Institute, the Trauma Centre for Survivors of Violence and Torture, and intergenerational trauma experts to develop evidence-based, community-based interventions that draw from the idea of Ubuntu Circles of healing as articulated in the NSP on GBVF (2.6.2., p 94) to provide safety nets to foster healing and addressing historical trauma in a community-centred way.

A List of Stakeholders*

Individual Level

Department of Social Development (DSD); Department of Basic Education (DBE); South African Police Service (SAPS); Department of Health (DoH); Mental Health Organisations such as the South African Depression and Anxiety Group (SADAG); Non-Governmental Organisations (NGOs) such as Sonke Gender Justice and Child Welfare South Africa; Civil Society Organisations (CSOs); Community-Based Organisations (CBOs); Academic Institutions and Research Bodies; the Department of Higher Education and Training (DHET); Department of Women, Youth and Persons with Disabilities; and the Department of Communications and Digital Technologies (DCDT); to develop and oversee a government-wide communication strategy.

Interpersonal Level

Stakeholders who should collaborate in implementing gender-transformative and economic empowerment opportunities for women and their families include: Department of Small Business Development (DSBD); Department of Economic Development; National Treasury; Private Sector, and NGOs such as the Women's Legal Centre and South African Women in Dialogue (SAWID).

For recommendations related to family matters: collaboration between NGOs such as Child Welfare South Africa; Lifeline South Africa; the Gender-Based Violence Command Centre; and the Department of Justice and Constitutional Development (DJCD) is suggested

Community Level

To address harmful gender stereotypes, promoting gender-equitable relationships, and the implementation of culturally relevant, community-based interventions, the following departments and organisations are identified: the Department of Women, Youth and Persons with Disabilities; Government Communication and Information System (GCIS); Department of Communications and Digital Technologies (DCDT); Department of Cooperative Governance and Traditional Affairs (COGTA); NGOs such as Gender Links and Sonke Gender Justice; and relevant CBOs etc.

Societal Level

Stakeholders that play a critical role in the above recommendations include a variety of government departments already mentioned, including the Department of Justice and Constitutional Development (DJCD); Department of Transport (DOT); Department Sport, Arts and Culture (DSAC); Department of Agriculture, Land Reform and Rural Development (DALRRD); DoH; DSD; SAPS; NGOs such as Sonke Gender Justice and the Centre for the Study of Violence and Reconciliation (CSVR); and SADAG etc.

A Call for Long-Term and Holistic Approaches

The following stakeholders address the structural factors contributing to GBV, while developing long-term, culturally relevant, and intersectionality informed approaches: Presidency (Office of the President) should promote a whole-of-government approach and ensuring coordinated action across different sectors in collaboration with DWYPD, DSD; DoH; DBE; DHET; Department of Women, Youth and Persons with Disabilities; Department of Cooperative Governance and Traditional Affairs (COGTA); Local Governments; DPME; CSOs such as the Trauma Centre for Survivors of Violence and Torture; CBOs; Academic Institutions and Research Bodies; NGOs etc.

*The list of stakeholders provided is not exhaustive and can still be expanded.

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APPENDIX

Appendix A: Description of the measures used

The WHO Women's Health and Life Experiences Questionnaire version 12.06 was updated in 2020. The original instrument was developed in 2005 and implemented across various country contexts and settings including Bangladesh, Cambodia, Japan, Namibia, Peru, Tanzania, Samoa and Thailand.[82] The WHO Violence Against Women instrument that was used in the WHO Multi-Country Study on Women's Health and Domestic Violence Against Women is widely used in South African studies on GBV,[186-189] including a study conducted with women living with disabilities.[190] It is also commonly used within SADC, with Gender Links having conducted eight GBV surveys using the instrument.[191] A study conducted in Sweden testing psychometric properties was able to demonstrate good construct validity and internal reliability in an adult female population.[192] The women's questionnaires include scales that have been previously tested and validated. In addition, we compared earlier versions of the Women's Health and Life Experiences questionnaire, namely Version 9.9 used in SADC and Version 12.0 used in Cambodia, with the latest edition, Version 12.06, to develop an instrument suitable for the South African setting.

Earlier versions of the WHO Women's Health and Life Experiences questionnaire questionnaires had 12 sections: (a) characteristics of the respondent and her community; (b) general health status; (c) reproductive health; (d) information about children; (e) characteristics of current or most recent partner; (f) attitudes toward gender roles; (g) experiences of partner violence; (h) injuries due to violence; (i) impact and coping mechanisms used by women or men who experience violence; (j) experiences of non-partner violence; (k) financial autonomy; and (l) respondent feedback to complete the interview. It elicited information on community connectedness; general, mental and reproductive health; risk factors for HIV; partner relationships; practices and gender roles within partnerships; experiences of partner violence and injuries due to violence; coping mechanisms and support structures; experiences of non-partner violence; and financial autonomy.

Revisions were made to selected questions in version 12.6 and, where relevant, we retained questions from 9.9 taking into account indicators specific to the South African context. Female genital mutilation, one of three optional topics, as listed in the Guidelines for Producing Statistics on VAW, is not a common practice in South Africa so it was omitted from the SA questionnaire. The demographic section of the questionnaire has been adapted to be comparable with other South African national surveys (such as the DHS and SABSSM). The household questionnaire and the demographic section of the WHO questionnaire has been adapted using questions from the above-mentioned national studies. Specific items include gender-sensitive demographics, marriage/partnership, and migration. While polygamy is a common practice in certain cultures in South African, extensive information about the number and standing of each wife was also left out. We retained the core topics as per the WHO guidelines for producing statistics for VAW. These include i) physical violence, ii) sexual violence, iii) psychological violence and iv) economic violence. We have omitted extensive sections focusing of have omitted extensive sections focusing of children and their exact ages.

We have also included questions on risk related to GBV such as HIV-related risk (condom and multiple sexual partners), alcohol and other drug use, and trafficking for sexual exploitation. We also measure the association of GBV with mental health, such as childhood trauma, depression, PTSD, and substance use and abuse. The mental health and substance abuse scales we used have been used previously with similar populations.[152,193-195] Lastly, to understand the experiences of victimisation and perpetration of GBV during COVID-19 lockdowns in South Africa, we adapted questions from the Citizen Survey conducted by UN Women for this purpose. Lastly, we included questions about a local practice called '*ukuthwala*'. This practice is a form of abduction that involves a man and his friends or peers kidnapping a girl or a young woman with the intention of compelling her family to endorse marriage negotiations.[196] It is often violent and is planned without her or her parents' consent nor knowledge.

The Core Men's Questionnaire's objectives are to: 1) better understand men's use of different forms of violence against women (specifically, intimate partner violence and non-partner rape), 2) assess men's own experience of violence as well as their perpetration of violence against other men and how it relates to the perpetration of violence against women, 3) identify factors associated with men's perpetration of different forms of violence against women, and 4) promote evidence-based policies and programmes to prevent violence against women. Similar to the WHO Violence Against Women instrument, the Men's questionnaire was adapted for the South African context for comparability with other national surveys such as DHS and SABSSM. The Core Men's Questionnaire was adapted from eight sections to seven sections, namely: socio-demographic characteristics and employment, childhood experiences, attitudes about relations between men and women (using the GEM Scale), intimate relationships, health and well-being, (using the CES depression scale and suicide ideation, life satisfaction scale and empathy scale), policies, and a self-administered section that includes questions about behaviours related to sexual and reproductive health including, HIV and other sexually transmitted infections; number of sex partners; engagement in transactional sex; use of sexual violence against women or men (partners and non-partners); history of criminal behaviour, including stealing, fights, gangs, arrest, and/or imprisonment; alcohol or drug use; experience of violence outside the home; sexual orientation; sex with men; and indicators of socio-economic status.

Appendix B: Definitions of the primary outcomes and drivers of women's experience of IPV and socio-behavioural variables

Outcome	Definition
Economic abuse by an intimate partner	Has your husband or any other partner: • prohibited you from getting a job, going to work, trading, earning money or participating in income-generating projects? • taken your earnings from you against your will • refused to give you money you needed for household expenses even when he has money for other things (such as alcohol and cigarettes)? Has this happened in the past 12 months? Respondent has experienced at least one economically abusive act by their intimate partner in their lifetime (lifetime experience of economic abuse) and/or in the past 12 months (recent experience of economic abuse).
Emotional abuse by an intimate partner	Has your husband or any other partner: • insulted you or made you feel bad about yourself • belittled or humiliated you in front of other people • deliberately done things to scare or intimidate you (e.g. by the way he looked at you, by yelling, or smashing things) • verbally threatened to hurt you or someone you care about? Has this happened in the past 12 months? Respondent has experienced at least one emotionally abusive act by an intimate partner in their lifetime (lifetime experience of emotional abuse) and/or in the past 12 months (recent experience of emotional abuse).
Physical violence by an intimate partner	Has your husband or any other partner: • slapped you or thrown something at you that could hurt you • pushed you or shoved you or pulled your hair • hit you with his fist or with something else that could hurt you • kicked you, dragged you or beaten you up • choked or burnt you on purpose • used a gun, knife, or other weapon against you, or threatened to? Has this happened in the past 12 months? Respondent has experienced at least one act of physical violence by an intimate partner in their lifetime (lifetime experience of physical violence by a partner) and/or in the past 12 months (recent experience of physical violence by a partner).
Sexual violence by an intimate partner	Has your husband or any other partner: • ever forced you to have sexual intercourse when you did not want to, for example by threatening you or holding you down • ever force you to do anything else sexual that you did not want or that you found degrading or humiliating? Have you ever had sexual intercourse when you did not want to because you were afraid of what your partner or husband might do if you refused? Has this happened in the past 12 months? Respondent has experienced at least one act of sexual violence by an intimate partner in their lifetime (lifetime experience of sexual violence by a partner) and/or in the past 12 months (recent experience of sexual violence by a partner).
Physical and/or sexual violence by an intimate partner	Respondents who have experienced at least one act of physical violence only or at least one act of sexual violence only or both physical and sexual violence by an intimate partner in their lifetime (lifetime experience of physical and/or sexual violence by a partner) Respondents who have experienced at least one act of physical violence only or at least one act of sexual violence only or both physical and sexual violence by an intimate partner in the past 12 months (recent experience of physical and/or sexual violence by a partner)
Non-partner physical violence	Since the age of 15, has anyone, other than your partner: • slapped, hit, beaten, kicked or done anything else to hurt you • thrown something at you • pushed you or pulled your hair • choked or burnt you on purpose • used a gun, knife, or other weapon against you, or threatened to? Has this happened in the past 12 months? Respondent has experienced at least one act of physical violence by a non-partner (lifetime experience of non-partner physical violence) and/or in the past 12 months (recent experience of non-partner physical violence).
Non-partner sexual violence	Since the age of 15, has anyone, other than your partner: • forced you into a sexual act when you did not want to, for example by threatening you, holding you down, or putting you in a situation where you could not say no • forced you to have sex when you were too drunk or drugged to refuse? Has any of this happened in the past 12 months? Respondent has experienced at least one act of sexual violence by a non-partner (lifetime experience of non-partner sexual violence) and/or in the past 12 months (recent experience of non-partner sexual violence).

Non-partner physical and/ or sexual violence	Respondents who have experienced at least one act of physical violence only or at least one act of sexual violence only or both physical and sexual violence by a non-partner in their lifetime (lifetime experience of physical and/or sexual violence by a non-partner) Respondents who have experienced at least one act of physical violence only or at least one act of sexual violence only or both physical and sexual violence by a non-partner in the past 12 months (recent experience of physical and/or sexual violence by a non-partner)
Experienced any physical violence (regardless of partnered status)	Respondent has experienced at least one act of physical violence by an intimate partner or by a non-partner (lifetime experience of physical violence) as well as in the past 12 months (recent experience of physical violence).
Experienced any sexual violence (regardless of partnered status)	Respondent has experienced at least one act of sexual violence by an intimate partner or by a non-partner (lifetime experience of sexual violence) as well as in the past 12 months (recent experience of sexual violence).
Experienced any physical and/or sexual violence (regardless of partnered status)	Respondent has experienced at least one act of physical violence only or at least one act of sexual violence only or both physical and sexual violence by an intimate partner or by a non-partner (lifetime experience of physical and /or sexual violence) as well as in the past 12 months (recent experience of physical and /or sexual violence).
Controlling behaviours	Has your husband or any other partner: ● tried to keep you from seeing your friends ● tried to restrict contact with your family of birth ● insisted on knowing where you are at all times ● ignored you and treated you indifferently ● become angry if you speak with another man ● been suspicious that you are unfaithful ● expected you to ask his permission before seeking health care for yourself Respondent has experienced at least one act by an intimate partner in their lifetime

Disability	Measuring disability is important as it estimates of prevalence of persons with disabilities, identifies their needs and allows for more inclusivity in studies. The short set of questions developed by the Washington Group on Disability Statistics (WG) is adaptable and reproducible and provides valuable insight into persons living with different levels of functioning, making it more inclusive.a However, it does not consider persons with intellectual difficulties.[b] It also measures current disability, and although we have looked at lifetime physical and sexual violence and women who have experienced childhood physical and sexual abuse in persons with disabilities, we are unable to determine causality. We cannot ascertain with these measures whether those who have experienced abuse as children or as adults became disabled at that time or whether their disabilities preceded their experiences of violence. The Washington Group Short Set of Disability Questions (WG-SS)[c]: ● Do you have difficulty seeing, even if wearing glasses ● Do you have difficulty hearing, even if using a hearing aid? ● Do you have difficulty walking or climbing steps? ● Do you have difficulty remembering or concentrating? ● Do you have difficulty with self-care, such as washing all over or dressing? ● Using your usual (customary) language, do you have difficulty communicating, for example, understanding or being understood? Respondents who answered that they have 'no difficulty' or 'yes some difficulty' to all of the questions were classified as having no disability. Respondents who answered 'yes a lot of difficulty' or 'cannot at all' to any of the questions were classified as having a disability.[d]

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b. Michael Palmer, David Harley, Models and measurement in disability: an international review, Health Policy and Planning, Volume 27, Issue 5, August 2012, Pages 357–364, https://doi.org/10.1093/heapol/czr047.

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d. Dunkle K, Gibbs A, Chirwa E, et al. How do programmes to prevent intimate partner violence among the general population

Socio-behavioural variables	Definition
Number of sexual partners in one's lifetime	In your life how many different men have you had sex with? Categorised into: 1 sexual partner, 2–3 sexual partners, 4+ sexual partners
Current condom use	• What (main) method are you currently using to delay or avoid pregnancy? • If you did not list condoms as your main method, do you also make use of condoms to avoid pregnancies?
Generalised anxiety disorder	The Generalised Anxiety Disorder 7-item (GAD-7) is a screening tool for generalised anxiety disorder [a]. Over the last two weeks, how often have you: • been nervous, anxious, or on edge • not been able to stop or control worrying • worried too much about different things • had trouble relaxing • been so restless that it's hard to sit still • become easily annoyed or irritable • felt afraid as if something awful might happen? Responses for the seven items were used to compute a sum score, which was categorised as: (0–4) mild anxiety, (5–9) moderate anxiety, 10+ moderate/severe anxiety a. Spitzer RL, Kroenke K, Williams JB, Löwe B. A brief measure for assessing generalised anxiety disorder: the GAD-7. Arch Intern Med. 2006;166:1092-7.
Depression	Patient Health Questionnaire (PHQ-9) is a screening tool for depression [a] Over the last 2 weeks, how often have you; • had little interest or pleasure in doing things • felt down, depressed or hopeless • had trouble falling or staying asleep • felt tired or had little energy • had a poor appetite or overeaten • felt bad about yourself – or that you are a failure or have let yourself or your family down • had trouble concentrating on things, such as reading the newspaper or watching television • moved or spoken so slowly that other people could have noticed, or been so fidgety or restless that you moved around a lot more than usual • thought that you would be better off dead, or considered hurting yourself in some way? Sum score categorised into: (0): not at all, (1–4): minimal depression, (5–9): mild depression, (10–14): moderate depression, (15–19): moderately severe depression, (20–27): severe depression. a. Kroenke K, Spitzer RL. The PHQ-9: a new depression diagnostic and severity measure. Psychiatr Ann. 2002;32:509-21.
Lifetime suicidal ideation	In your life, have you ever seriously thought about ending your life?
Current frequency of alcohol intake	How often do you have a drink containing alcohol? • Every day or nearly every day • Once or twice a week • 1 - 3 times in a month • Less than once a month • Never
Lifetime drug use	Have you ever used drugs (e.g. marijuana, tik, cannabis)?
History of childhood physical abuse	When you were a child, before you were 15 years old, did anyone in your family: • slap or spank you with a hand • beat, kicked, or hit you with fist • hit you with a belt, stick, broom or something else • tied you with a rope? Respondent experienced at least one of these physical abusive acts.
History of childhood sexual abuse	When you were a girl, before you were 15 years old, do you remember if any-one in your family ever touched you sexually against your will, or made you do something sexual that you didn't want to? For example, has any of these things ever happened to you? Touching of breasts, genitals, penis, vagina, or anus, making sexual remarks or showing sexual explicit pictures against your will, making you touch their genitals, penis, vagina, or anus, having sex or trying to engage in sexual acts with you? Apart from anything you may have mentioned, can you tell me if, since the age of 15 until now, any of the following has happened to you? • Has anyone attempted but NOT succeeded to force you into a sexual act when you did not want to, for example by holding you down or putting you in a situation where you could not say no? • Touched you sexually against your will. This includes for example touching of breasts or genital area, penis, vagina or anus? • Made you touch their private parts against your will? Respondent experienced at least one of these sexually abusive acts.
History of childhood emotional abuse	When you were a child (before age 15), did anyone in your family ever insult or humiliate you regularly?
Reported that mother was abused by a partner	When you were a child, was your mother hit by your father (or her husband or boyfriend)?

Attitudes and perceived norms about gender relations	Please answer according to your feelings about each statement: 1 . Agree, 2. Somewhat agree, 3. Disagree. ● A woman's most important role is to take care of her home and cook for her family. ● Men need sex more than women do. ● It is a woman's responsibility to avoid getting pregnant. ● A woman should tolerate violence in order to keep her family together. ● If someone insults a man, he should defend his reputation, with force if he has to. ● To be a man, a person needs to be tough. ● A man should have a final word about decision in his home. Sum score categorised into: low, medium, high equitable views using equal categories
Food insecurity	In case of emergency, do you think that you alone could raise enough money to house and feed your family for four weeks?
Quarrel with partner	How often would you say that you quarrel with a partner? Would you say rarely, sometimes or often?
Marriage characteristics: Age at the first time of being married or living together with a man	Question was asked to respondents who reported having ever been married or had lived with a man. Integer response was categorised into: <18 years, 18–24 years, >=25 years
Attitudes towards gendered power relations	Please tell me whether or not you agree with the following statements: ● I think that if a wife does something wrong her husband has the right to punish her. ● I think that if a man has paid bride price for his wife, he owns her. ● I think that if a man has paid bride price for his wife, she must have sex when he wants it. ● I think that if a man beats you it shows that he loves you. Respondent either agreed, somewhat agreed or disagreed for each of these statements.

Appendix C: Definitions of the primary outcomes and drivers of men's perpetration of IPV

Outcome	Definition
Lifetime economic abuse	● Have you ever prohibited a partner from getting a job, going to work, trading or earning money? If yes, did this happen once, a few times or many times? ● Have you ever taken a partner's earnings against her will? If yes, did this happen once, a few times or many times? ● Have you ever thrown a partner out of the house? If yes, did this happen once, a few times or many times? ● Have you ever kept money from your earnings for alcohol, tobacco or other things for yourself when you knew your partner was finding it hard to afford the household expenses? If yes, did this happen once, a few times or many times? ● Have you done any of these things in the past 12 months?
Lifetime emotional abuse	● Have you ever insulted a partner or deliberately made her feel bad about herself? If yes, did this happen once, a few times or many times? ● Have you ever belittled or humiliated a partner in front of other people? If yes, did this happen once, a few times or many times? ● Have you ever done things to scare or intimidate a partner on purpose for example by the way you looked at her, by yelling and smashing things? If yes, did this happen once, a few times or many times? ● Have you ever threatened to hurt a partner? If yes, did this happen once, a few times or many times? ● Have you ever hurt people your partner cares about as a way of hurting her, or damaged things of importance to her? If yes, did this happen once, a few times or many times? ● Have you done any of these things in the past 12 months?
Ever perpetrated physical violence	● Have you ever slapped a partner or thrown something at her that could hurt her? If yes, did this happen once, a few times or many times? ● Have you ever pushed or shoved a partner? Did this happen once, a few times or many times? ● Have you ever hit a partner with a fist or with something else that could hurt her? If yes, did this happen once, a few times or many times? ● Have you ever kicked, dragged, beaten, choked or burned a partner? If yes, did this happen once, a few times or many times? ● Have you ever used a gun, knife or other weapon against a partner, or threatened to? If yes, did this happen once, a few times or many times? ● Have you done any of these things in the past 12 months?
Ever perpetrated sexual violence	● Have you ever coerced/forced and/or manipulated your current or previous wife or girlfriend to have sex with you when she did not want to? ● Have you ever had sex with your current or previous wife or girlfriend when you knew she didn't want it, but you believed she should agree because she was your wife/partner? ● Have you ever coerced/forced or manipulated your current or previous wife or girlfriend to watch pornography when she didn't want to? ● Have you ever coerced/forced or manipulated your current or previous wife or girlfriend to do something sexual that she did not want to do? ● Have you done any of these things in the past 12 months?

Ever perpetrated physical and/or sexual violence	• Men who have ever perpetrated both (at least one act of physical and at least one act of sexual violence) in their lifetime • Men who have ever perpetrated both physical and sexual violence in the past 12 months
Driver	**Definition**
Main source of income	Who provides the main source of income in your home? • self • partner • both equally • parents • other
	What was your main source of income in the last month? • salary/earnings • contributions by family members or relatives • government pensions/grants (e.g., ol old age pension, child support grant, disability grant • grants/donations by private welfare organisations • other sources
Marriage characteristics	Age the first time you got married: • <18 years • 18–24 years • >=25 years
Marriage characteristics	How did you come to marry your current or most recent wife? • we chose each other • marriage was arranged • marriage was negotiated with elders, and she had to agree • *ukuthwala*
Marriage characteristics	What is the most wives you have had at the same time? • one • two • three • four
Marriage characteristics	Did your marriage involve a dowry or *lobola* payment? • yes dowry • yes *lobola* • no dowry or *lobola*
Partner's age	What is the age gap between you and your current/ most recent wife/partner/ girlfriend? • partner is ≥5 years older • partner is ≥5 years younger • partner is ≤ 5 years older or younger

Transactional sex	Please think about any women/girl/man/boy you have had sex with, even if it was just once. Do you think any of them may have become involved with you because you (or they expected you to): • provided them with drugs, food, cosmetics, clothes, cellphone, transportation or anything else they couldn't afford themself • provided them with somewhere to stay • gave them items or did something for their children or family • gave them cash or money to pay their bills or school fees Have you ever had sex with a prostitute or sex worker?
Lifetime number of sex partners	How many different people have you had sex with in your WHOLE LIFE? This includes your wife or long-term partners as well as anyone you may have had sex with even if only once, including sex workers: • 1 sex partner • 2–3 sex partners • ≥ 4 sex partners
Substance use: **Hazardous drinking or active alcohol use disorders (AUDIT-C)**	How often do you drink alcohol? • every day or nearly every day • once or twice a week • 1–3 times a month • less than once a month • never How many drinks containing alcohol do you have on a typical day when you are drinking? • 1 or 2 • or 4 • or 6 • 7–9 • 10 or more How often do you have six or more drinks on one occasion? • never • less than monthly • monthly • weekly • daily or almost daily Categories: hazardous drinking, no hazardous drinking
Drug use	How many times have you used drugs in the last 12 months? Categories: do not use drugs, use drugs

Depression **Center for Epidemiologic Studies Depression scale (CES-D)**	All the below questions had four options: rarely or none of the time, some or a little of the time (1-2 days), moderate amount of time (3-4 days), most or all of the time (5-7 days) • During the past week I was bothered by things that usually don't bother me. • During the past week I did not feel like eating, my appetite was poor. • During the past week I felt I could not cheer myself up even with the help of family and friends. • During the past week I felt I was just as good as other people. • During the past week I had trouble keeping my mind on what I was doing. • During the past week I felt depressed. • During the past week I felt that everything I did was an effort. • During the past week I felt hopeful about the future. • During the past week I thought my life had been a failure. • During the past week I felt fearful. • During the past week my sleep was restless. • During the past week I was happy. • During the past week I talked less than usual. • During the past week I felt lonely. • During the past week people were unfriendly. • During the past week I enjoyed life. • During the past week I had crying spells. • During the past week I felt sick. • During the past week I felt that people dislike me. • During the past week I could not get 'going'. Categories: not at risk clinical depression, at risk for clinical depression
Suicidal ideation	I now want you to think about your whole life experience. Have you ever thought about ending your life? Categories: yes, no
Satisfaction with Life Scale (SWLS)	Now I will read some statements about how you see your life and please tell me if you strongly agree, agree, disagree or strongly disagree • In most ways my life is close to my ideal • The conditions in my life are excellent • I am satisfied with my life • So far I have gotten the important things I want in life Categories: higher/neutral, lower
Childhood emotional trauma	• Before I reached 18: • I saw or heard my mother being beaten by her husband or boyfriend • I was told I was lazy or stupid or weak by someone in my family • I was insulted or humiliated by someone in my family in front of other people
Childhood emotional neglect	Before I reached 18: • I spent time outside the home and none of the adults at home knew where I was • I lived in different households at different times • I did not have enough to eat • one or both of my parents were too drunk or drugged to take care of me
Childhood physical abuse	Before I reached 18; • I was beaten or physically punished at school by a teacher or headmaster • I was beaten at home with a belt or stick or whip or something else that was hard • I was beaten so hard at home that it left a mark or bruise
Childhood sexual abuse	Before I reached 18: • I had sex with someone because I was threatened or frightened or forced • someone touched my buttocks or genitals or made me touch them when I did not want to • I had sex with a woman who was more than 5 years older than me
Overall childhood trauma scale	Categories: low (0–3), medium (4–6), high (7+) from combining childhood trauma and neglect for emotional, physical and sexual abuse
Bullying	• Were you yourself bullied, teased or harassed in school or in the neighbourhood in which you grew up? • Did you bully, tease or harass others? Categories: yes/no
Gender equitable norms	I will now ask you about your views on life and particularly on relations between men and women in society. There are no right or wrong answers – we are just interested in what you think. Please tell me whether you strongly agree, agree, disagree or strongly disagree with the following statements: • A woman's most important role is to take care of her home and cook for her family. Men need sex more than women do. • There are times when a woman deserves to be beaten. It is a woman's responsibility to avoid getting pregnant. • A woman should tolerate violence in order to keep her family together. I would be outraged if my wife asked me to use a condom. • If someone insults me, I will defend my reputation, with force if I have to. • To be a man, a person needs to be tough. Categories: low, medium, high using equal categories

Gender equitable attitudes	Now I would like to ask your opinion on some statements on what you think about relations between men and women. Can you tell me if you strongly agree, agree, disagree or strongly disagree with the following statements: • I think that people should be treated the same whether they are male or female. • I think that a woman should obey her husband. • I think that a man should have the final say in all family matters. • I think that men should share the work around the house with women, such as doing dishes, cleaning and cooking. • I think that if a man has paid bride price for his wife, he owns her. • I think that a woman cannot refuse to have sex with her husband. • I think that if a wife does something wrong, her husband has the right to punish her. • I think that when a woman is raped, she is usually to blame for putting herself in that situation. • I think that if a woman doesn't physically fight back, it's not rape. • I think that it would be shameful to have a gay son. Categories: low, medium, high using equal categories
Controlling behaviours	I will read some statements about your relationship with your current or most recent wife or partner. Please tell me if you strongly agree, agree, disagree or strongly disagree: • When I want sex I expect my partner to agree. • If my partner asked me to use a condom, I would get angry. • I won't let my partner wear certain things. • I have more to say than she does about important decisions that affect us. • I tell my partner who she can spend time with. • When my partner wears things to make her look beautiful, I think she may be trying to attract other men. • I want to know where my partner is all of the time. • I like to let her know she isn't the only partner I could have. Categories: agree/strongly agree, disagree/strongly disagree
Empathetic concern	Now I'm going read some statements and would like to know how well they describe you. The options are: doesn't describe you at all, doesn't describe you well, either way, describes you quite well, describes you very well. • I often have tender, concerned feelings for people less fortunate than me. • When I see someone being taken advantage of, I feel protective towards them. • I am often touched by things that I see happen. • I would describe myself as a pretty soft-hearted person. Categories: lower empathic concern/ higher empathic concern
Food security	How often would you say that people in your home go without food because of lack of money: • every week • every month but not every week • it happens but not every month • never Categories: yes/no

Victimisation of men: sexual violence towards other men	• Have you ever done anything sexual with a boy or man when he didn't consent, or you coerced/forced or/and manipulated him? • Have you ever done anything sexual with a boy or man when you put your penis in his mouth or anus when he didn't consent or you forced him? • Have you and other men ever had sex with a man at the same time when he didn't consent to sex, or you coerced/forced or manipulated him? Categories: yes/no
Victimisation of men: physical and sexual violence	In the past 12 months, outside the home have you: • been punched or hit • been threatened with a knife or other weapon (excluding firearms) • been threatened with a gun? Categories: yes/no
How old were you the first time you coerced/forced or/and manipulated a woman or girl to have sex or had sex with her when she did not consent?	How old were you the first time you coerced/forced or/and manipulated a woman or girl to have sex or had sex with her when she did not consent? • ≤ 15 years old • 15–19 years old • 20–29 years old • 30–39 years old • 40 years or older • never
COVID specific questions: emotional abuse	During lockdown levels 4 and 5, did you humiliate, threaten to hurt or insult: • your partner, i.e., current wife/husband/partner, previous wife/husband/partner • other known female, i.e., family member, friend, or friend of family, • other person, i.e., father, stepfather, other male family member, teacher, police officer, soldier, male friend of family, stranger, someone at work, priest or religious leader? No, i.e., did not perpetrate emotional abuse during lockdown.
COVID specific questions: physical abuse	During lockdown levels 4 and 5, did you hit, slap, kick, or do anything else to physically hurt: • your partner, i.e., current wife/husband/partner, previous wife/husband/partner • other known female, i.e., family member, friend, or friend of family, • other person, i.e., father, stepfather, other male family member, teacher, police officer, soldier, male friend of family, stranger, someone at work, priest or religious leader? No, i.e., did not perpetrate physical abuse during lockdown.
COVID specific questions: sexual abuse	During lockdown levels 4 and 5, did you force sexual intercourse or perform any other non-consensual sexual acts on: • your partner, i.e., current wife/husband/partner, previous wife/husband/partner • other known female, i.e., family member, friend, or friend of family, • other person, i.e., father, stepfather, other male family member, teacher, police officer, soldier, male friend of family, stranger, someone at work, priest or religious leader? No, i.e., did not perpetrate sexual abuse during lockdown.

Awareness of laws of violence against women	Are there any laws in your country about violence against women? Categories: yes, no, do not know According to the law, is a husband who forces his wife to have sex against her will committing a criminal act (that is, the husband can be fined or put in jail)? Categories yes, no, do not know They make it too easy for a woman to bring a violence charge against a man. Categories: strongly agree/agree, no opinion, disagree/strongly disagree

Appendix D: Proposed stakeholders who should collectively be engaged to play a crucial role in addressing the implications and recommendations of the study

A List of Stakeholders*

Individual Level

Department of Social Development (DSD); Department of Basic Education (DBE); South African Police Service (SAPS); Department of Health (DoH); Mental Health Organisations such as the South African Depression and Anxiety Group (SADAG); Non-Governmental Organisations (NGOs) such as Sonke Gender Justice and Child Welfare South Africa; Civil Society Organisations (CSOs); Community-Based Organisations (CBOs); Academic Institutions and Research Bodies; the Department of Higher Education and Training (DHET); Department of Women, Youth and Persons with Disabilities; and the Department of Communications and Digital Technologies (DCDT); to develop and oversee a government-wide communication strategy.

Interpersonal Level

Stakeholders who should collaborate in implementing gender-transformative and economic empowerment opportunities for women and their families include: Department of Small Business Development (DSBD); Department of Economic Development; National Treasury; Private Sector, and NGOs such as the Women's Legal Centre and South African Women in Dialogue (SAWID).

For recommendations related to family matters: collaboration between NGOs such as Child Welfare South Africa; Lifeline South Africa; the Gender-Based Violence Command Centre; and the Department of Justice and Constitutional Development (DJCD) is suggested

Community Level

To address harmful gender stereotypes, promoting gender-equitable relationships, and the implementation of culturally relevant, community-based interventions, the following departments and organisations are identified: the Department of Women, Youth and Persons with Disabilities; Government Communication and Information System (GCIS); Department of Communications and Digital Technologies (DCDT); Department of Cooperative Governance and Traditional Affairs (COGTA); NGOs such as Gender Links and Sonke Gender Justice; and relevant CBOs etc.

Societal Level

Stakeholders that play a critical role in the above recommendations include a variety of government departments already mentioned, including the Department of Justice and Constitutional Development (DJCD); Department of Transport (DOT); Department Sport, Arts and Culture (DSAC); Department of Agriculture, Land Reform and Rural Development (DALRRD); DoH; DSD; SAPS; NGOs such as Sonke Gender Justice and the Centre for the Study of Violence and Reconciliation (CSVR); and SADAG etc.

A Call for Long-Term and Holistic Approaches

The following stakeholders address the structural factors contributing to GBV, while developing long-term, culturally relevant, and intersectionality informed approaches: Presidency (Office of the President) should promote a whole-of-government approach and ensuring coordinated action across different sectors in collaboration with DWYPD, DSD; DoH; DBE; DHET; Department of Women, Youth and Persons with Disabilities; Department of Cooperative Governance and Traditional Affairs (COGTA); Local Governments; DPME; CSOs such as the Trauma Centre for Survivors of Violence and Torture; CBOs; Academic Institutions and Research Bodies; NGOs etc.

*The list of stakeholders provided is not exhaustive and can still be expanded.

Appendix E: Comparison of demographic characteristics of the weighted survey sample versus Stats SA mid-year population estimates, 2022

	Weighted survey sample				Stats SA 2022 Mid-year population estimates			
	Women		Men		Women		Men	
Age group	n	%	n	%	n	%	n	%
18–24	3 533 755	15.9	3 585 145	17.7	3 533 755	15.9	3 585 144	17.7
25–29	2 907 947	13.1	2 825 292	13.9	2 907 947	13.1	2 825 292	13.9
30–34	2 816 611	12.7	2 776 212	13.7	2 816 611	12.7	2 776 212	13.7
35–39	2 625 710	11.8	2 596 891	12.8	2 625 711	11.8	2 596 891	12.8
40–44	2 096 143	9.4	2 089 076	10.3	2 096 144	9.4	2 089 077	10.3
45–49	1 706 813	7.7	1 586 697	7.8	1 706 813	7.7	1 586 698	7.8
50–54	1 491 230	6.7	1 277 910	6.3	1 491 229	6.7	1 277 910	6.3
55–59	1 395 675	6.3	1 100 778	5.4	1 395 674	6.3	1 100 778	5.4
60+	3 645 170	16.4	2 454 559	12.1	3 645 168	16.4	2 454 558	12.1
Race								
African	17 587 032	79.2	16 019 066	78.9	17 587 032	79.2	16 019 066	78.9
White	1 966 024	8.8	1 794 410	8.8	1 966 024	8.8	1 794 410	8.8
Coloured	1 899 516	8.5	1 646 791	8.1	1 899 516	8.5	1 646 791	8.1
Indian/Asian	679 058	3.1	690 125	3.4	679 058	3.1	690 125	3.4
Other	87 422	0.4	142 167	0.7	87 422	0.4	142 167	0.7
Province								
Western Cape	2 833 668	12.8	2 603 051	12.8	2 833 667	12.8	2 603 051	12.8
Eastern Cape	2 543 260	11.4	2 125 986	10.5	2 543 260	11.4	2 125 986	10.5
Northern Cape	475 693	2.1	424 814	2.1	475 695	2.1	424 812	2.1
Free State	1 079 734	4.9	930 019	4.6	1 079 733	4.9	930 018	4.6
KwaZulu-Natal	4 479 340	20.2	3 885 457	19.1	4 479 338	20.2	3 885 457	19.1
North-West	1 289 598	5.8	1 235 580	6.1	1 289 597	5.8	1 235 579	6.1
Gauteng	5 467 921	24.6	5 606 263	27.6	5 467 922	24.6	5 606 264	27.6
Mpumalanga	1 805 099	8.1	1 606 296	7.9	1 805 099	8.1	1 606 296	7.9
Limpopo	2 244 741	10.1	1 875 094	9.2	2 244 740	10.1	1 875 095	9.2
Total	22 219 052	100.0	20 292 559	100.0	22 219 052	100.0	20 292 559	100.0

Appendix F: Characteristics of marriage among women who were ever married

	%	95% CI	n
Age at the first time of being married or living together with a man			
<18 years	8.6	[6.8-10.7]	189
18–24 years	45.3	[42.2-48.4]	1 015
≥25 years	46.1	[42.6-49.7]	948
Does/did your partner have any other wives/husbands while being married to you?			
No	91.6	[89.7-93.2]	2 019
Yes	8.4	[6.8-10.3]	176

Marriage characteristics: Does/did your partner have any other wives/husbands while being married to you
Response options: No, Yes

Appendix G: Characteristics of marriage among men who were ever married

	%	95% CI	n
Age at the first time you got married:			
<18 years	1.2	[0.7-2.2]	17
18–24 years	22.6	[19.2-26.4]	314
≥25 years	76.2	[72.4-79.6]	1 177
How did you come to marry your current or most recent wife?			
We chose each other	89.3	[87.0-91.3]	1 530
Marriage was arranged	4.2	[3.1-5.6]	73
Marriage was negotiated with elders, and she had to agree	5.4	[4.2-7.0]	100
Ukuthwala	1.1	[0.6-2.1]	27
What is the most number of wives you have had at the same time?			
Only one	97.4	[96.3-98.2]	1 675
Two wives	2.2	[1.5-3.3]	38
Three wives	0.2	[0.1-0.6]	4
Four wives	0.2	[0.0-0.9]	2
Did your marriage involve dowry or *lobola* payment?			
Yes, dowry	7.4	[5.6-9.8]	121
Yes, *lobola*	59.9	[54.7-64.9]	1 103
No dowry or *lobola*	32.6	[28.4-37.2]	507

Appendix H: Numbers of all women aged 18 years and older who experienced physical and/or sexual violence by intimate partner(s) or non-partner(s), South Africa, 2022

	Prevalence (%)	Weighted count	95% CI	
Experiences of violence among all women				
Lifetime experiences				
Lifetime physical violence (partnered or non-partnered)	33.1	7 310 389	6 656 212	7 964 567
Lifetime sexual violence (partnered or non-partnered)	9.8	2 150 342	1 853 343	2 447 342
Lifetime physical and/or sexual violence (partnered or non-partnered)	35.5	7 847 438	7 171 040	8 523 837
Recent experiences				
Recent physical violence (partnered or non-partnered)	6.1	1 338 336	1 086 483	1 590 188
Recent sexual violence (partnered or non-partnered)	2.0	432 525	320 201	544 849
Recent physical and/or sexual violence (partnered or non-partnered)	7.0	1 536 729	1 271 271	1 802 186
Experiences of IPV among ever-partnered women				
Lifetime experiences				
Ever experienced physical IPV	22.4	3 221 649	2 804 091	3 639 207
Ever experienced sexual IPV	7.9	1 131 293	901 399	1 361 188
Ever experienced physical and/or sexual IPV	23.9	3 448 669	3 020 766	3 876 572
Recent experiences				
Experienced recent physical IPV	5.2	747 188	586 499	907 876
Experienced recent sexual IPV	2.5	354 196	257 017	451 376
Experienced recent physical and/or sexual IPV	6.4	925 261	745 523	1 104 999
Experiences of non-partner violence among all women				
Lifetime experiences				
Lifetime physical violence	24.6	5 417 522	4 864 875	5 970 169
Lifetime sexual violence	5.9	1 278 011	1 064 401	1 491 622
Lifetime physical and/or sexual violence	27.0	5 948 915	5 368 503	6 529 326
Recent experiences				
Recent physical violence	3.4	738 407	531 183	945 630
Recent sexual violence	0.6	124 438	66 252	182 624
Recent physical and/or sexual violence	3.7	807 260	597 079	1 017 441

Appendix I: Number of all men aged 18 years and older who perpetrated physical and/or sexual violence against intimate partner(s), South Africa, 2022

	Prevalence (%)	Weighted count	95% CI	
Perpetration of IPV among ever-partnered men				
Lifetime perpetration				
Ever perpetrated physical IPV	16.7	2 495 451	2 176 797	2 814 105
Ever perpetrated sexual IPV	7.5	917 395	731 568	1 103 223
Ever perpetrated physical and/or sexual IPV	20.5	3 192 790	2 834 060	3 551 519
Recent perpetration				
Perpetrated physical IPV in past 12 months (recent)	2.4	366 030	232 988	499 071
Perpetrated sexual IPV in past 12 months (recent)	2.3	284 311	195 542	373 081
Perpetrated physical and/or sexual IPV in past 12 months (recent)	4.0	627 939	473 813	782 066

Appendix J: Number of all women and men aged 18 years and older who ever experienced childhood abuse, South Africa, 2022

	Prevalence (%)	Weighted count	95% CI	
Prevalence of childhood abuse				
Childhood abuse among all women before age 15				
Childhood history of physical abuse	58.0	11 996 096	11 101 905	12 890 287
Childhood history of sexual abuse	4.0	880 530	640 782	1 120 279
Childhood abuse among all women with a disability before age 15				
Childhood history of physical abuse	62.3	981 166	845 796	1 116 535
Childhood history of sexual abuse	4.2	71 471	28 007	114 935
Childhood abuse among all men before age 18				
Childhood history of physical abuse	74.6	14 558 519	13709878	15 407 161
Childhood history of sexual abuse	15.7	3 055 810	2 652 377	3 459 244

Appendix K: Numbers of all women aged 18 years and older with a disability who experienced physical and/or sexual violence by intimate partner(s) or non-partner(s), South Africa, 2022

	Prevalence (%)	Weighted count	95% CI	
Experiences of violence among all women with a disability				
Lifetime experiences				
Ever Physical violence (partnered & non partnered)	40.4	685 208	550 686	819 731
Ever Sexual violence (partnered & non partnered)	15.3	257 103	177 988	336 217
Ever Physical and/or sexual violence (partnered & non partnered)	42.5	722 857	581 931	863 783
Recent experiences				
Recent Physical violence (partnered & non partnered)	4.3	71 879	29 341	114 416
Recent Sexual violence (partnered & non partnered)	2.6	44 269	12 670	75 869
Recent Physical and/or sexual violence (partnered & non partnered)	5.3	89 905	42 405	137 405
Experiences of IPV among ever-partnered women with a disability				
Lifetime experiences				
Ever experienced Physical IPV	29.3	358 817	262 960	454 675
Ever experienced Sexual IPV	14.6	178 193	109 363	247 023
Ever experienced Physical and/or Sexual IPV	31.2	383 175	284 938	481 413
Recent experiences				
Experienced recent Physical IPV	4.3	52 489	15 735	89 243
Experienced recent Sexual IPV	3.6	44 269	12 671	75 868
Experienced recent Physical and/or Sexual IPV	6.9	84 147	37 520	130 773
Experiences of non-partner violence among all women with a disability				
Lifetime experiences				
Ever Physical violence	28.2	477 148	367 667	586 628
Ever Sexual violence	8.2	136 365	86 471	186 259
Ever Physical and/or sexual violence	31.7	538 300	424 325	652 275
Recent experiences				
Recent Physical violence	2.1	35 224	6 477	63 970
Recent Sexual violence	0.3	4 606	4 443	13 656
Recent Physical and/or sexual violence	2.1	35 224	6 477	63 970

Appendix L: Comparison of the current findings on physical and/or sexual violence with findings from other national and international estimates of victimisation and perpetration.

	SAGBV 2022	SADHS 2016	WHO global estimates 2018	UN men's 2013
GBV victimisation	%	%	%	%
All women				
Physical violence	33.1			
Sexual violence	9.8			
Physical and/or sexual violence	35.5		30.0	
IPV (ever-partnered women)				
Physical violence	24.6	20.5		35.2
Sexual violence	7.9	6.2		26.9
Physical and/or sexual violence	23.9	21.3	26.0	42.9
Non-partnered women				
Physical violence	24.6			
Sexual violence	5.9		6.0	
Physical and/or sexual violence	27.0			
GBV perpetration				
IPV (ever-partnered men)				
Physical violence	16.7			32.9
Sexual violence	7.5			24.3
Physical and/or sexual violence	20.5			45.6

Appendix M: Comparison of the current findings on physical, emotional, and economic abuse including controlling behaviour with findings from other national and international estimates.

	SAGBV 2022	SADHS 2016	WHO global estimates 2018	UN men's 2013
GBV victimisation	%	%	%	%
IPV (ever-partnered women)				
Physical violence	24.6	20.5		35.2
Emotional abuse	25.1	17.1		49.5
Controlling behaviour	57.6	49.1		
Economic abuse	13.1			37.9
GBV perpetration				
IPV (ever-partnered men)				
Physical violence	16.7			32.9
Emotional abuse	33.6			53.2
Controlling behaviour	77.2			
Economic abuse	14.8			34.0

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