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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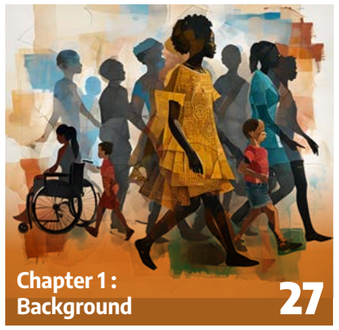

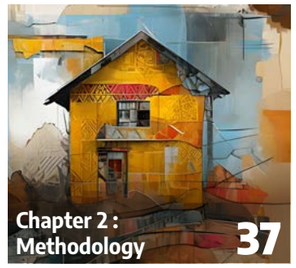

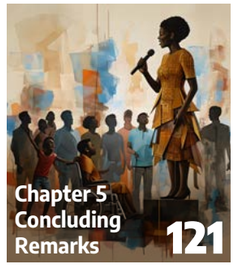

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Briefings: Department of Women, Youth, and Persons with Disabilities

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 ministers office.

ACRONYMS AND ABBREVIATIONS

AGYW	Adolescent girls and young women
CBO	Community-based organisation
CES-D	Centre for Epidemiologic Studies Depression scale
DHS	Demographic 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 Health Survey
SALs	Small area layers
SDG	Sustainable Development Goals
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. Private 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'. 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 instil 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 behaviours 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 Health Survey (SADHS), and the South African National HIV Prevalence, Incidence, Behaviour, and Communication Survey (SABSSM). Police data is known for pervasive underreporting 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 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 describe the prevalence and patterns of experiences of physical, sexual, emotional and economic GBV among women from all provinces in South Africa

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

Methodology

Study design

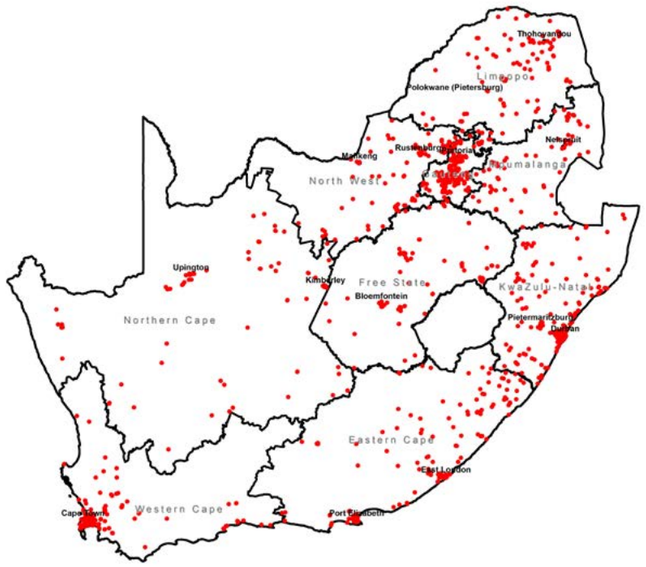
The study is a population-based household survey, conducted using a multi-stage stratified cluster random sampling design.

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 (VP) 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

Below is a summary of national prevalence estimates for physical, sexual, emotional, and economic violence, and psychological abuse such as controlling behaviours. 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. Where applicable, weighted numbers are also provided.

Prevalence of different forms of GBV 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.

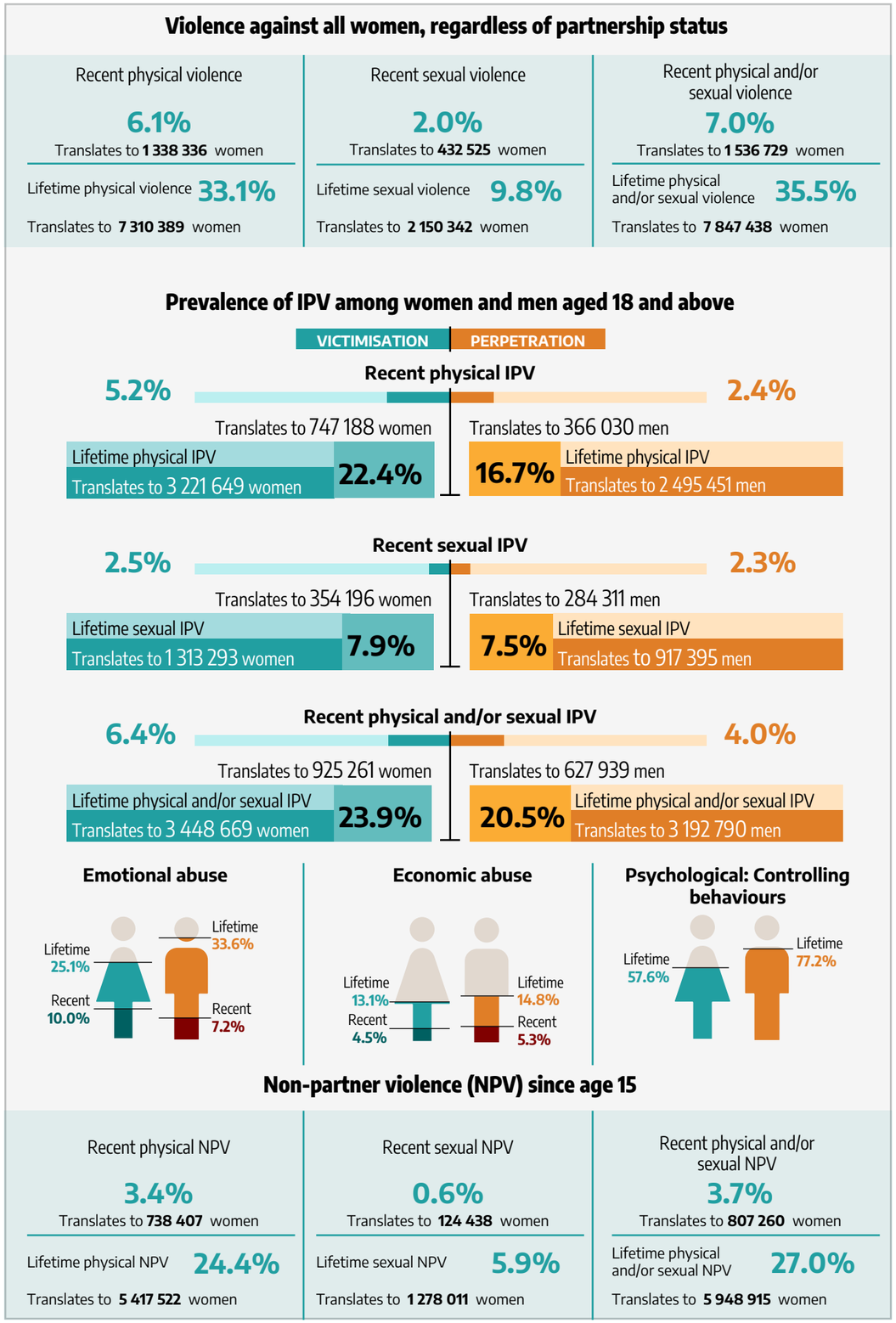
Prevalence of lifetime sexual violence regardless of partnered status

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: The prevalence of different forms of gender-based violence among women aged 18 years and older, South Africa 2022



Prevalence of GBV in previous 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).

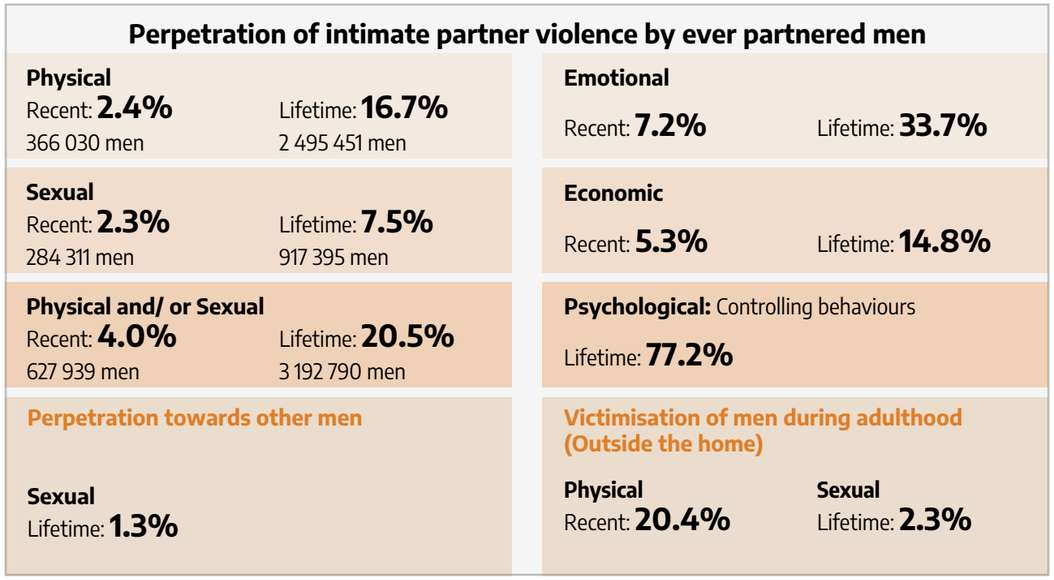
Overall, 6.1% [95% CI: 5.1-7.3] of women reported that they had experienced physical violence in the past 12 months. This translates to an estimated 1 338 336 women who were physically violated in South Africa in a period of 12 months.

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



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]
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 lower [21.0, 95% CI: 17.6-24.8], medium [18.7%, 95% CI: 14.8-23.2], or 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] 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 sexual intimate partner violence (IPV) perpetration by men

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.

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	**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]
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, 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, 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] 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]

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 to 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.

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 last 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 last 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 behaviours 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 behaviours 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 lifetime 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.

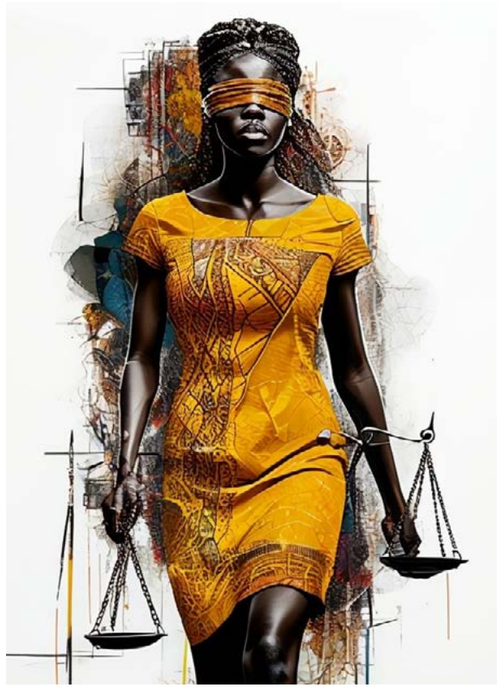
When men were presented with statements that were designed to measure gendered norms, attitudes and gendered power relations, a large proportion of ever-partnered men [66.6%, 95% CI 63.9-69.1] agreed that a woman's most important role is to take care of her home and cook for her family, followed by 54.4% [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

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 regards 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 task 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 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.

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 behaviours.
- 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 behaviours, 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 overall livelihoods of both men and women, with a especially focus on youth and women with disabilities.

Strengthening family interventions by:

- increasing investment in evidence-based family support programmes to prevent, 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).
- changing 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 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. In the NSP on GBVF, under Pillar 2, the NSP of GBVF suggested 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.