

Determinants of Intimate Partner Violence in Sub-Saharan Africa: A Review of Prevention and Intervention Programs

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Intimate partner violence (IPV) in sub-Saharan Africa affects 36% of the population. Several African countries rank among the highest globally. In this article, we present evidence on the prevalence, determinants, and impact of IPV across several sub-Saharan African countries interpreted against the backdrop of social ecological theory. We also describe prevention or intervention programs tested in different regions of Africa, selecting only those programs which were published in a journal outlet and which met a high criteria of implementation and methodology ($n = 7$). Based on our review of the empirical literature, some risk factors for violence documented in Western societies are the same in Africa, including poverty, drinking, a past history of child abuse or posttraumatic stress disorder, and highly traditional gender role beliefs. Low education is also associated with IPV for both women and men. In Africa, partner abuse intersects with the HIV pandemic, making violence prevention especially urgent. African programs to prevent IPV are often incorporated with HIV prevention; community building and community engagement are emphasized more in Africa than in North

America or Europe, which invoke more individually focused approaches. Some programs we review lowered HIV exposure in women; others contributed to reduced violence perpetration among men. The programs show sufficient promise to recommend replication and dissemination in sub-Saharan Africa.

KEYWORDS: IPV; intimate partner abuse; domestic violence prevention; spouse abuse; partner abuse; sexual violence

Intimate partner violence (IPV) is widespread throughout much of sub-Saharan Africa,¹ with the overall past-year prevalence of 36% exceeding the global average (30%; García-Moreno et al., 2013). More women in Africa are subject to lifetime partner violence (45.6%) and sexual assault (11.9%) than women anywhere in the world, with the notable exception of high-income countries in the case of rape (12.6%; García-Moreno et al., 2013). In the past 15 years, a growing number of population-based surveys of representative samples have improved our understanding of the scope and determinants of IPV on the African continent. Most epidemiological or demographic studies in Africa focus on women as victims and men as perpetrators, although there are some which include both sexes as either victim or perpetrator (Andersson, Ho-Foster, Mitchell, Scheepers, & Goldstein, 2007; Gass, Stein, Williams, & Seedat, 2011; Jankey, Próspero, & Fawson, 2011; Kaminer, Grimsrud, Myer, Stein, & Williams, 2008; Zungu, Salawu, & Ogunbanjo, 2010). Some of the risk factors for IPV in Africa mirror those found in other regions of the world such as individual-level characteristics (excessive drinking or a past history of child abuse) or socioeconomic conditions such as unemployment. In addition, long-standing patriarchal traditions play a role. African cultural beliefs and traditions promote men's hierarchical role in sexual relationships and especially marriage (Morrell, Jewkes, & Lindegger, 2012). To illustrate the widespread impact of such beliefs, in many places in East Africa, women usually do not have the freedom to choose their marriage partners and often are forced into marriages as prepubescent children. As many as 63% of the African population live in remote rural areas (World Bank, 2015b) separating communities from the influence of central government or the rule of law prohibiting gender-based violence. Twenty-one African countries have adopted strict laws against domestic violence and sexual assault, yet enforcement is elusive when large segments of the population live outside urban centers. Norms surrounding violence in families also change more slowly in rural areas (United Nations, 2012). In sub-Saharan Africa, gender relations incorporating violence reflect the legacy of conflict and hegemony which marked the colonial period and, in South Africa, the radical imposition of Apartheid in the 1940s (Jewkes & Morrell, 2010). Economic and political transformation has actually left many men without a clear position provoking tension in the relationships between men and women (Boonzaier, 2005).

One framework to explain the multidimensional reasons for intimate partner abuse is the ecosocial model which promotes the analysis of culture and relationships

within the wide social environment (Bronfenbrenner, 1977; Heise, 1998). Bronfenbrenner's (1977) ecological framework organizes risk factors according to at least four putative levels: personal characteristics (individual), the family or close relationships (microsystem), the societal and community influences (exosystem), and sociocultural forces and the belief systems (macrosystem). The advantage of such a model is that individual behaviors are seen as resulting from "intersectional" influences or the socially constructed identities individuals carry. Ecosocial models have been applied to IPV (Bograd, 1999; Djamba & Kimuna, 2015; Heise, 1998; Oetzel & Duran, 2004) and to the interface between child maltreatment and domestic violence (Little & Kantor, 2002). Capaldi, Knoble, Shortt, and Kim (2012) adopt a developmental systems approach together with macro and ecosocial influences to interpret the risk factors for dating and IPV.

Beliefs relating to gender roles in marriage lay the groundwork for IPV in many regions of Africa. Patriarchal beliefs are not the only explanation for partner abuse but such attitudes sustain community tolerance of IPV reducing the chance for a systemic social response. In sub-Saharan Africa, a significant proportion of *both* men and women endorse a man's prerogative to physically discipline his wife (Koenig et al., 2003), with more women than men endorsing what they view as *justified* abuse, such as when a wife appears to neglect the children or argues with her husband (Uthman, Lawoko, & Moradi, 2009). Such findings illustrate that patriarchal ideology is often equally shared by men and women in Africa; efforts to change ideology need to address both sexes.

To understand the origins of intimate partner abuse in Africa, it is important to interpret the problem against the context of family life and gender roles (Boonzaier & de La Rey, 2003; Jewkes & Morrell, 2010). In some regions, women face pronounced gender-based discrimination across the life course as reflected in the practices of female genital mutilation (FGM), "bridewealth," polygamy, and exclusion from education. The belief that women's sexual response must be suppressed, that she should be traded for marriage by her father, and that her husband is free to take multiple wives sets the stage for the commodification of women and the acceptance of violence in support of a husband's effort to control. In fact, according to the United Nations gender equality index, which includes data on reproductive health, employment, and empowerment, 27 of the 30 most gender unequal countries in the world are in Africa (United Nations Development Programme, 2013).² For example, in 10 African countries, girls' access to education falls below Pakistan (Hausmann, Tyson, & Zahidi, 2009). Cross-national comparisons reveal that countries with low social equality between the sexes generate more criminal victimization of women (Yodanis, 2004).

IPV has adverse outcomes for women ranging from poor psychological health to adverse reproductive health effects such as poor birth outcomes (Campbell, 2002). Africa is at the forefront of deadly emerging infections such as HIV which has levied a catastrophic toll on the population with 78 million deaths recorded worldwide since 1980 (World Health Organization [WHO], 2015). About two thirds of the world's HIV-infected population live in sub-Saharan Africa carrying a disease burden of

about 24.7 million.³ The association of IPV with HIV has surfaced in several studies across Africa (Burgos-Soto et al., 2014; Dunkle & Decker, 2013; Durevall & Lindskog, 2015; Jewkes, Sikweyiya, Morrell, & Dunkle, 2011; Maman et al., 2002). IPV, therefore, shares the stage with the world's most lethal emergent infection.

Multiple interventions addressing IPV have been attempted and evaluated in sub-Saharan Africa. African programs emphasize community building and community engagement more than the programs we see promoted in North America or Europe. Furthermore, these programs typically adopt a nonjudgmental, nonpunitive approach toward perpetrators. The criminal justice approach widely used in North America which links arrest to treatment is largely absent; arrests are atypical, and diversion postarrest is not an option. Some approaches to HIV prevention have emphasized enhanced couple equality and repudiation of intimate violence with the aim of changing norms especially among young adults. In this review, therefore, we will include studies which focus on one or several intersecting pathways to perpetration, the impact of IPV, and the efforts to prevent or end it.

PREVALENCE OF INTIMATE PARTNER VIOLENCE IN SUB-SAHARAN AFRICA

As previously mentioned, some of the highest global prevalence rates are in Africa (García-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005; United Nations, 2012). Violence against wives and sexual partners is so common in some countries that it is virtually ubiquitous as in Zambia (90%) and Ethiopia (71%; United Nations, 2012; Table 1). In Uganda, 41% of the women reported at least one episode of IPV directed against them in the past year (Kwagala, Wandera, Ndugga, & Kabagenyi, 2013). Yet, prevalence ranges from a low of 18% in Nigeria (and even 3% in some rural areas) to 49% in South Africa with uniform measurement and sampling approaches (García-Moreno et al., 2005). The co-occurrence of sexual assault with physical and psychological partner abuse highlights the unique burden for women in abusive relationships. Indeed in the Congo where as many as 1.8 million women reported rapes because of the civil war and political chaos, an additional 3.37 million disclosed rape in their marriages, nearly double the number attributed to political violence (Peterman, Palermo, & Bredenkamp, 2011). Such a finding illustrates that even in the context of war where rape was used to generate terror, the sexual abuse women endure in marriage is even more widespread and persistent. Intimate partner abuse and sexual assault occur early in the lives of many African women because they either enter marriage unions in their teenage years or mature sexual relationships early, as in Southern Africa, with at least half of teens entering relationships with men more than 5 years their senior. Involvement with age-disparate men has been linked to HIV (Jewkes et al., 2006). Based on findings from a meta-analysis, Decker et al. (2015) found that teenage girls (aged 15–19 years) and young women (aged 20–24 years) in Southern Africa (e.g., South Africa, Botswana) disclose the highest prevalence of partner violence victimization

TABLE 1. Lifetime Prevalence of Women's Physical and Sexual Abuse Victimization

SADC Countries for Which Data Exist (Taken From UN Women [2012] Table)		
Country	Lifetime Prevalence Physical and Sexual Abuse (%)	Source
Democratic Republic of the Congo	64.1	DHS, 2007
Malawi	31.0	DHS, 2010
Mozambique	31.5	DHS, 2011
Namibia	35.9	WHO (García-Moreno et al., 2005)
Zimbabwe	42.3	DHS, 2011
Other African Countries (Taken From UN Women [2012] Table)		
Kenya	41.2	DHS, 2009
Cameroon	51.1	DHS, 2011
Ethiopia	70.9	WHO (García-Moreno et al., 2005)
Liberia	38.6	DHS, 2007
Nigeria	18.3	DHS, 2008
Rwanda	56.4	DHS, 2011
Uganda	50.5	DHS, 2011
Tanzania	43.6	DHS, 2011
SADC Countries Prevalence Data (Taken From SADC Gender Protocol Barometer [Gender Links, 2014])		
Zimbabwe	69.0	GL, 2014
Lesotho	62.0	GL, 2014
Botswana	60.0	GL, 2014
Mauritius	23.0	GL, 2014
Zambia	90.0	GL, 2014
South Africa	49.0	GL, 2014

Note. DHS = The Demographic and Health Surveys, Domestic Violence Module country reports (The Demographic and Health Surveys Program. [n.d.]. *DHS final reports*. Retrieved from <http://www.measuredhs.com/publications/publication-search.cfm?type=5>); SADC = Southern African Development Community; UN = United Nations; WHO = World Health Organization; GL = Gender Links.

compared to matched age cohorts in different countries worldwide. The highest rates of forced sex in marriage occurred against girls (aged 15–19 years) in Uganda (30%), Democratic Republic of Congo (32.5%), and Zimbabwe (16.5%; Decker et al., 2015). The most harrowing outcome of IPV is injury-related fatality, and IPV accounts for many of the homicides of women in South Africa (Abrahams et al., 2009;

Stöckl et al., 2013). In a large-scale study of homicide records in several African countries, husbands or partners were responsible for 44.8% of all homicides against women with only 4.4% of homicides against men being committed by women partners (Stöckl et al., 2013).

The prevalence of women as perpetrators of partner abuse in sub-Saharan Africa ranges from fairly low in South Africa for “hitting, pushing, or slapping,” the most common forms of partner abuse (Kaminer et al., 2008), to 34% in a Kenyan population-based survey (Simister, 2010). About 25% of South African women in a nationally representative study reported perpetrating some form of partner abuse, comparable to the percent of men’s reports (Gass et al., 2011). In a household survey of several thousand men and women conducted in mainly rural areas across eight sub-Saharan countries, 14% of men and 18% of the women reported partner abuse victimization notwithstanding wide differences in prevalence between countries and even within countries by languages spoken (Andersson et al., 2007). According to these researchers, the largest gender gaps in self-reports of victimization were in the two countries with the lowest (Malawi) and the highest (Zambia) overall prevalence of partner violence—more than twice as many women as men disclosed victimization in Malawi (11% vs. 6%) and 42% more in Zambia (36% vs. 21%). In Zambia, the Lozi speakers exhibited the highest rates against women (54%) in the study (Andersson et al., 2007). Despite the impressive scope of the sampling design for this comparative study, the measurement of IPV was inadequate, restricted to a single yes/no question which collapsed severe (e.g., beating) and moderate (e.g., slapping) violence omitting questions about sexual coercion. It is well known in survey research that using more items increases the likelihood of detecting stigmatized social behaviors such as IPV. When questionnaire results in Andersson et al.’s (2007) are compared to those from a recent population-based study in Malawi, which used more items including sexual coercion, the percentage of women reporting IPV victimization doubled (Bazargan-Hejazi, Medeiros, Mohammadi, Lin, & Dalal, 2013) from 11% in Andersson et al.’s study to 21% in Bazargan-Hejazi et al.’s, with data collected in the same decade.

To recapitulate, in some African countries, men are in receipt of physical partner abuse, although with the wide variance in the definitions used for partner abuse and the types of abuse being measured (e.g., physical, sexual, psychological, or verbal) and especially cross-national comparisons, are hard to interpret. Moreover, without having the data to reflect the severity of violence as committed by either men or women, direct comparison between the sexes is inconclusive. Although homicide is a rare event, the pattern of women falling victim to a partner far more often than men described earlier (Stöckl et al., 2013) is likely to reflect underlying gender differences in the use of severe and injurious violence against a partner. In the United States, for instance, women are 10 times more likely to report being beaten by a spouse than are men (Tjaden & Thoennes, 2000). Similar patterns were identified in an American study of domestic violence treatment showing that both men and women reported slapping or hitting at similar rates, but severe violence was disproportionately

committed by men (Cantos, Neidig, & O'Leary, 1994). Indeed, *severe* violence is typically gender asymmetrical as reflected in one study of South Africans with 14% of young women experiencing it and only 2%–4% of young men (WHO, 2013).

There are few or no research reports of *exclusive* partner violence by women which does not, of course, imply that such situations are entirely absent from the African context. Indeed, in the Nyeri region of Kenya, journalists have reported on what appears to be asymmetrical and severe abuse by some wives against their husbands; the women justify their attacks by impugning their husbands' drinking or failure to sustain employment, in other words, for failing to uphold male gender roles in marriage mirroring the excuses given for beating wives.²

Although women in Africa may display physical and psychological aggression toward men partners (Esquivel-Santoveña, Lambert, & Hamel, 2013), there are such large gaps in power and resources that the meaning of physical abuse may be different. This is not to say that some men may not experience distress in the aftermath of a wife's assault, but men's violence is supported by a spectrum of oppressive cultural practices. In contrast, women who aggress are often shunned in the community and their own victimization ignored (Uthman et al., 2009). Poverty and gender inequality sometimes converge to entrap women within chronically abusive relationships, whereas African men can and do walk away.

DETERMINANTS OF INTIMATE PARTNER VIOLENCE IN SUB-SAHARAN AFRICA

Determinants of IPV can be classified according to the ecosocial model encompassing exo- and macrocultural levels of analysis. At the societal level of analysis (exosystem), for male perpetrators low socioeconomic status (SES; Capaldi et al., 2012; Gass et al., 2011) and especially unemployment are associated with abuse in the family including against children (Steinberg, Catalano, & Dooley, 1981) and wives (Fox & Benson, 2006). Low SES emerges as a risk factor in high-income countries for perpetration by either men or women (Capaldi et al., 2012; Gass et al., 2011). Risk factors at the individual level include a childhood history of abuse in either the perpetrator or the victim (Herrenkohl et al., 2004), the acceptance of social norms of male dominance and tolerance of physical violence in close relationships (Reitzel-Jaffe & Wolfe, 2001; Stith, Smith, Penn, Ward, & Tritt, 2004), exposure to parental violence prediction perpetration of spouse abuse in both men and women (Gass et al., 2011), and alcohol use on the part of the perpetrator (Kantor-Kaufman & Straus, 1987). In the WHO cross-national report, many of the same correlates surfaced—SES, alcohol abuse, cohabitation, and childhood history of abuse—across cultures and regions (García-Moreno et al., 2013). The authors note that when risk variables were shared between the partners—as in alcohol abuse—the association was the strongest. Further risk factors emanating from the social conditions and norms in particular African contexts are described in the following text, with the caveat that cultural norms vary from one country and region to the other.

MACRO INFLUENCES

Gender Ideology and Attitudes Toward Partner Violence

Another expression of macro influences pertains to culture and cultural beliefs. Although we assume that cultural beliefs are important to study because of their putative role in behavior, the connection between beliefs or attitudes and behavior is notoriously hard to capture empirically (Azjen & Cote, 2008). The earliest research to demonstrate no association was in the study of prejudice: Many studies failed to trace a clear link from prejudice to discriminatory behavior. It is therefore unsurprising that gender ideology is not perfectly associated with abusive behavior among men, for instance, yet some research indicates it does play a role (Stith et al., 2004). Young men who hold rigid views about gender roles tend to endorse the use of physical abuse to control a woman partner (Maldonado, Watkins, & DiLillo, 2015; Reitzel-Jaffe & Wolfe, 2001). Adolescent boys who express strong beliefs in “courtship patriarchy,” which highlights the importance of girls’ subordinate role and behavior in a dating relationship, are more tolerant of attitudes supporting IPV (Lichter & McCloskey, 2004). These studies are cross-sectional and causality therefore cannot be established (Dutton, 1994). In a cross-national survey of attitudes toward intimate partner abuse, including 17 sub-Saharan countries, most men supported using violence against a wife for disagreeing with or arguing with the husband or going out without notifying him (Uthman et al., 2009). The approval of physical abuse in marriage was particularly widespread in Zambia (71%) and Kenya (68%). African men endorse the use of physical violence against partners they deem as “disobedient,” as shown in a study of rural families in Uganda—70% of men agreed with statements supporting violence against wives (Koenig et al., 2003). Higher income men with higher educational attainment, who lived in cities, were less likely to endorse physical abuse in intimate relationships. Factors affecting approval include men’s higher educational level in Kenya (Lawoko, 2008). In addition, men who placed a value on shared decision making were less prone to physical abuse against a wife or partner, although they were in the minority. Although researchers have largely concentrated on men’s attitudes toward spouse abuse, women also show tolerance of men’s use of physical tactics against wives (Koenig et al., 2003). Women from the same communities in Rakai, Uganda, in which 70% of the men approved of violence against wives, were even more likely to support men’s use of violence with 90% expressing approval. Although it is often assumed that men’s attitudes are the main determinants in their use of force in relationships, further research on women’s acceptance of men’s violence is warranted.

The pathways by which cultural norms lead to violence in intimate relationships are complex and have not been well elucidated. Traditional gender role beliefs, per se, fail to fully account for male-perpetrated IPV in the United States (Sugarman & Frankel, 1996), and in a recent review (Esquivel-Santoveña, Lambert, & Hamel, 2013), the authors were unable to find significant correlations between a country’s low ratings on measures of women’s empowerment and rates of IPV victimization.

On the other hand, in another cross-national study using the International Crime Victims Survey, the United Nations gender equity scores did predict women's victimization and especially sexual assault: The lower the gender equality in a society, the higher the sexual victimization (Yodanis, 2004). The link between misogynist attitudes and behavior was strong in a population-based survey of young adult men in the United States (Santana, Raj, Decker, La Marche, & Silverman, 2006) and the attitude-behavior connection was also reported in Archer's (2006) meta-analysis. Yet, Dutton (1994) has suggested that for (North American) abusive men beliefs in traditional gender roles are an *excuse for*, rather than a cause of, their behavior, with personality and relationship factors more relevant. There may be cultural differences, however, in how much is explained by individual pathology as opposed to gender attitudes. Relationship conflict may be linked to individual pathology and escalating conflict dynamics in more gender egalitarian societies, whereas social norms may drive relationship conflicts in traditional, patriarchal countries.

Attitudes toward physical abuse by the husband in marriage have early origins in the treatment of girls and women in Africa. Gender inequality begins at a young age in most communities, and after cumulative socialization of women into subordinate roles, it is perhaps unsurprising that many adopt the patriarchal tenets they grew up on. African girls are placed at serious disadvantage early when they are subjected to genital cutting to enhance their marriageability (Goldberg, 2013). It is estimated that approximately 27 million women in sub-Saharan Africa self-report receiving female circumcision or genital mutilation in childhood; 98% of Somalian women have undergone FGM.⁴ The expectations surrounding marriage often yoke girls and young women to unwanted partners. A bleak example is in Tanzania, where one in four girls who are raped are forced to marry their assailants exposing them to further abuse after marriage (Williams, McCloskey, & Larsen, 2008). Marriages are often arranged through bridewealth or "brideprice" thereby tying women to debt and servitude, whereas their husbands exercise their right to polygamous unions (Ellsberg, Heise, Peña, Agurto, & Winkvist, 2001). Furthermore, if husbands perceive a wife to be infertile, they may beat and abandon her; as in Tanzania, where women who have difficulty conceiving are at the highest odds of victimization compared to fertile women with few children (McCloskey, Williams, & Larsen, 2005). In this population-based study, polygamy and women's lower educational levels (less than primary school completion) also raised the risk. Moreover, women's infertility is seen as justification for husbands' violence with infertile women more than twice as likely to report abuse than women with children (Shah et al., 2013). In the same study, 59% of women surveyed maintained that they would rather discover that they were HIV positive than infertile. In summary, a range of practices and beliefs alongside the low-status position of women results in the widespread social sanctioning of men's violence against their wives or partners across a range of African contexts. The cultural practices and beliefs embedded in many African communities establish many gender-specific obstacles for girls and women, creating barriers for prevention or intervention.

EXOSYSTEM INFLUENCES

Poverty

In general, poverty increases the risk of IPV (Fox & Benson, 2006; Hotaling & Sugarman, 1990). Heise and García-Moreno (2002) found that across a range of global contexts, women living in poverty were disproportionately affected by IPV. They point out that the stress of men's unemployment can trigger discord, which increases the risk for partner violence. In support of this proposition, Cunradi, Todd, Duke, and Ames (2009) found that sudden job loss among Canadian construction workers sparked relationship strain and men's abuse of partners, even independently of drinking. Child abuse also increases after fathers lose their jobs in industrial regions of the United States (Steinberg et al., 1981). In a longitudinal study of women in India, the odds of men's violence against their wives increased almost two-fold after a husband's recent job loss; abuse also increased if the wife *gained* employment prior to the interview (Krishnan et al., 2010). Such findings point toward a "backlash" effect of women's employment vis-à-vis men's unemployment: Women who earn more than their partners may face a heightened risk of physical abuse at home (MacMillan & Gartner, 1999; McCloskey, 1996). A study in Uganda was designed to assess whether women's employment advantage affected her chances of partner violence, positing that "empowerment" as indexed by earning capability would deter violence (Kwagala et al., 2013). In Uganda, it did; fewer employed women were abused than unemployed women, and women with earning power or of higher SES were less susceptible to abuse. Although only one study, we may postulate that in sub-Saharan Africa, with high rates of deprivation, a woman's earning power may discourage her partner from physical abuse; the backlash effect detected elsewhere may be more pronounced in regions with rising economic expectations.

Africa is the poorest region in the world with up to 80% of the population living under the global poverty threshold (World Bank, 2015b). Even in South Africa, which has the second highest gross domestic product (GDP) in the region next to Nigeria, 26% of the country's population live on no more than \$2 a day. In many other countries, the percentage living at the same cutoff is staggering: 73% in Tanzania and 95% in Liberia (World Bank, 2015b). The legacy of Apartheid in South Africa imposes its own burden on the formerly oppressed population that is interwoven with cumulative disadvantage. Testing the relative effects of poverty in Africa on marital discord is a challenge because poverty is so endemic in this part of the world. In fact, Jewkes, Levin, and Penn-Kekana (2002) found that family income and other demographic variables were unrelated to partner violence in South Africa, concluding that poverty may even serve a protective function in severely deprived South African households, in which the main source of financial support was received from a third party (e.g., government aid), thereby lowering the potential for marital conflict over resources. Jewkes et al. also found that although it is not poverty or unemployment itself that may be a risk factor for violence, but the existence of only one partner supporting the household was a risk factor. This finding points to the potential of conflict

over resources and power disparities between partners as a better explanation than sociodemographic factors.

Law Enforcement and Community Norms

Additional exosystem influences—including perceived societal and government-sponsored policies about abuse in marriage—also influence people's beliefs about the acceptability of domestic violence according to one multilayered survey in Nigeria (Linos, Slopen, Subramanian, Berkman, & Kawachi, 2013). More than 18,000 women were interviewed about their own abuse and their beliefs about whether abuse against women partners is warranted. Women who endorsed wife abuse were more likely to be recipients of partner violence. In those communities where the government was unlikely to uphold laws protecting women against abuse or rape, more women were victimized; conversely, rates were lower in those states banning the practice with sanctions (Linos et al., 2013). The state's explicit messages, therefore, shape community norms surrounding violence in marriage; laws and policies prohibiting IPV may directly reduce rates of perpetration in African communities.

Individual Characteristics

Alcohol. Drinking has long been identified with wife abuse (Kantor-Kaufman & Straus, 1987). In one U.S. household survey, as many as 41% of the incidents of men's abuse of their partners were alcohol-related (Caetano, Cunradi, Clark, & Schafer, 2000). Drinking increases the chance of inflicting serious injuries because of a lack of self-control and judgment. In a recent longitudinal study, young men's adolescent substance abuse predicted the dissolution of later sexual partnerships and domestic violence, pointing to a causal pathway with origins in adolescence (Boden, Fergusson, & Horwood, 2013). Excessive alcohol consumption and dependence are catalysts for the perpetration of partner abuse by both males and females according to a large South Africa study (Gass et al., 2011). Conflict over a husband's drinking and a wife's alcohol consumption were associated with men's violent behavior against wives in South Africa (Jewkes et al., 2002). When women drink to excess, they break gender norms which some husbands believe entitles them to the exercise of physical punishment. The link between alcohol and violence may thus be mediated by beliefs about masculinity acted out through heavy drinking and violence (Jewkes et al., 2002). In a population-based study of more than 5,000 residents of Rakai, Uganda, men's alcohol consumption combined with their belief that they were HIV positive increased the odds of violence against women partners (Koenig et al., 2003; Zablotska et al., 2009). A study in rural Nigeria also showed a strong link between men's drinking and perpetration of partner violence (Brisibe, Ordinioha, & Dienne, 2012).

Past History of Abuse and Psychopathology as Risk Factors for Perpetrators. Men's past history of child abuse is related to their later perpetration of wife abuse

(Abramsky et al., 2011; Stith et al., 2004). In a meta-analysis, Stith et al. (2004) found that growing up in a violent home was significantly associated with perpetrating abuse against a partner. Those men who had been abused as a child or witnessed domestic violence were more likely than women to become perpetrators. In South Africa, Gass et al. (2011) found that the experience of childhood abuse along with exposure to parental violence predicted spouse abuse in both men and women. Reitzel-Jaffe and Wolfe (2001) contend that what appears to be an intergenerational cycle of intimate partner abuse is mediated by three factors, namely, negative beliefs about women, tendencies toward violence with men, and the preference for and influence of antisocial peers. They conclude that individual acquisition of aggressive behavior in intimate relationships cannot be understood without examining sociocultural forces, highlighting the important role of gender-role attitudes.

Past history of child abuse was a strong indicator of men's violence in Uganda, over and above other correlates (Kwagala et al., 2013). In a study of more than 1,000 municipal workers in Cape Town, South Africa, researchers also found evidence for an intergenerational cycle in men: The frequency of physical beatings as a child or witnessing the mother's abuse was associated with perpetration of IPV (Abrahams, Jewkes, Laubscher, & Hoffman, 2006). Of those who witnessed their mothers being abused (23.5%), 62.4% reported physically abusing women partners. Those men who witnessed their mothers' abuse committed other forms of violence, including fights with other men in their communities and at their places of work. In addition, men who described a distant relationship with their father or paternal abandonment were more likely to abuse women.

Various expressions of psychopathology, some of which might originate from child maltreatment, have been observed in men who assault their partners. For instance, a high proportion of men who are in treatment or under arrest for partner violence were diagnosed with borderline personality disorder, a complex disorder of unstable mood and identity (Dutton & Starzomski, 1993). A study of more than 1,600 men patients in an urban hospital showed a strong relationship between self-reported perpetration of partner abuse and a range of psychiatric disorders including depression and posttraumatic stress disorder (PTSD; Rhodes et al., 2009). Based on an analysis of more than 11,000 men in the National Epidemiologic Survey of Alcohol and Related Conditions (NESARC), those men with lifetime PTSD were more than twice as likely to report perpetration of violence against a partner (Hahn, Aldorando, Silverman, McCormick, & Koenen, 2015).

Nearly one in five men in South Africa meet the clinical criteria for psychiatric disorders, most notably phobias (especially agoraphobia) and depression (Williams et al., 2008). One in three South Africans confront serious, often life-threatening violence (Kaminer et al., 2008). For women, the source tends to be intimate partner and sexual abuse; for men, criminal assaults by other men. Moreover, lifetime diagnosis of PTSD in South African men resulted from experiences of torture and political detention during Apartheid. Although there do not appear to be studies directly connecting PTSD or other psychiatric diagnoses with intimate partner abuse in sub-Saharan

Africa, there is reason to believe that mental health problems may increase the risk for explosive rage and violent behavior in the home.

The Impact of Intimate Partner Violence in Africa

Psychological Effects on Women. IPV is associated mental health disorders notably clinical levels of depression and PTSD (Campbell, 2002; Pico-Alfonso et al., 2006). African women show several psychological disorders in response to intimate partner abuse. In Rwanda, women exposed to partner abuse met the criteria for several psychiatric disorders, with the most common diagnosis being depression (measured with the Composite International Diagnostic Interview [CIDI]; Umubyeyi, Mogren, Ntaganira, & Krantz, 2014). Ethiopian women were also more depressed if they reported IPV (Deyessa et al., 2009). Severe and chronic IPV was associated with women's PTSD in South Africa (Kaminer et al., 2008). Both men and women manifested psychological symptoms in the aftermath of a physical altercation, although symptoms were more enduring and associated more with fear among college-aged women than men in Botswana (Jankey et al., 2011).

Reproductive Health. Reproductive health can be compromised in several ways, from raising the risk of STIs to threatening a pregnancy (Hathaway, Willis, Zimmer, & Silverman, 2005). IPV is associated with sexually transmitted infections (STIs; Seth, Raiford, Robinson, Wingood, & DiClemente, 2010) which in Africa carry significance as potential gateways to HIV infection (Abu-Raddad et al., 2008). Violence during pregnancy elevates the odds of miscarriage, infant low-birth weight, and obstetric complications (Newberger et al., 1992). Women in Cameroon with a violent partner have more unwanted pregnancies as reflected by a higher number of abortions among obstetric patients (Alio et al., 2011). In Cameroon and many parts of Africa, especially rural, women seek abortions outside of the medical sphere, which may result in infection and death (Alio et al., 2011). Furthermore, according to one study of urban obstetric patients in Zimbabwe, if they become pregnant against the wishes of their husband, they are more likely to be abused during pregnancy (Shamu, Abrahams, Zarowsky, Shefer, & Temmerman, 2013). Pregnancy confers some protection against physical spouse abuse for women in this same study, but the prevalence of physical or sexual abuse during pregnancy is among the highest ever reported globally (42%). Birth spacing is also reduced in couples with a history of violence (Hung, Scott, Ricciotti, Johnson, & Tsai, 2012). Finally, infant care is threatened by IPV in Africa, with mothers less likely to feel free to breastfeed their newborns, compromising infants' well-being and even survival (Misch & Yount, 2014).

HIV/AIDS. HIV has migrated to nearly every corner of the globe with most new cases in sub-Saharan Africa, concentrated especially in the South (e.g., South Africa, Botswana, Zimbabwe, Zambia; Joint United Nations Programme on HIV/AIDS [UNAIDS], 2013). Multiple sexual relationships outside marriage are fairly

widespread in parts of Southern Africa, increasing the spread of HIV and creating asymmetrical exposure to the disease among wives who are generally more monogamous than their husbands (Kalichman et al., 2007). Yet, the distribution of the disease is asymmetric with more women becoming infected at an earlier age than men (Kapiga et al., 2006). The co-occurrence of IPV with HIV/AIDS has been observed in at-risk populations across many countries and social landscapes (Dunkle & Decker, 2013). Yet, the association is of special significance for Africa because of the sheer number of carriers among people who are otherwise in their prime. Among women seeking HIV testing in Dar Es Salaam, Tanzania, women who reported IPV were 10 times more likely to test positive than nonabused women (Maman et al., 2002). Causal evidence is available from a 2-year prospective study in South Africa showing that young women negative for HIV at the outset and in violent and unequal relationships were 53% more likely to test positive for HIV at the end of 2 years compared to women who were not in abusive relationships (Dunkle et al., 2004). Different forms of gender-based violence are implicated in the transmission of HIV to women, including sexual assault (Jewkes et al., 2011). In their review of the evidence for the link between partner violence and HIV, Dunkle and Decker (2013) point to the fact that men who are violent against their partners often have other characteristics that place them at an elevated risk for STIs and ultimately HIV such as alcohol abuse, multiple sexual partners, refusing condom use, and forcing sex. These findings were confirmed and expanded in a 12-country demographic survey of violence, health, and HIV in sub-Saharan Africa (Durevall & Lindskog, 2015). The researchers found that men who were abusive were more likely to have contracted HIV because of other risky behaviors. The link between violence and HIV transmission to women, they contend, is not because of violent behavior or even sexual coercion in marriage but excessively controlling behavior. Men who are occasionally violent but otherwise uncontrolling were no more likely to infect their wives than nonviolent men, but the characteristic of excessive control, also known as patriarchal terrorism (Johnson, 1995), enhanced the risk for their wives. In Togo, a West African country, the prevalence of HIV is fairly low in the heterosexual population (<4%) yet IPV is strongly associated with acquiring the virus (Burgos-Soto et al., 2014). In this study, men having multiple partners is associated with their own and their wives' HIV infection but of special interest is the close association between men having multiple partners and their perpetration of IPV. There appears to be triangulated risk in this case and in others of men's multiple and simultaneous sexual relationships, IPV, and HIV.

Many of the HIV prevention programs in sub-Saharan Africa which have met with some success in curbing the spread of the disease concentrate prevention efforts on women, ignoring the fact that IPV typically undermines women's agency in her sexual life. Prevention health workers may encourage women to ask a husband to use a condom, to chastise him for infidelity, and to refuse unsafe sex. All such responses are among the "triggers" women have identified as leading to violence (Kim & Watts, 2005) because they provide challenges to men's authority in the relationship.

METHOD

Procedure

The studies and programs we have selected are not meant to be exhaustive but represent some of the strongest empirical investigations on the topic in this region. Criteria for inclusion in this article were (a) population-based sampling or (b) unique study designs and large samples for the analysis of determinants (c) and published after 1994 (d) in a peer-reviewed journal. To obtain findings on the comparative prevalence, risk factors, and impact of IPV in sub-Saharan Africa, we sought studies based on population-based sampling methods. In addition, especially for prevalence statistics, we consulted government-sponsored websites and those of nongovernment organizations such as the United Nations, the World Bank, the WHO, and the CIA for population statistics. It should be noted that many of the authors use different questionnaires or assessment tools, therefore differences between countries may be in part attributable to instrument variation. Our initial database searches (MEDLINE, ISI-Web of Science, JSTOR, PubMed, Google Scholar) yielded more than 70,000 citations. Using the keywords noted below yielded the following results from JSTOR:

- Intimate partner violence and sub-Saharan Africa = 2,259
- Domestic violence and sub-Saharan Africa = 2,788
- Relationship violence and sub-Saharan Africa = 4,230
- Interpersonal violence and sub-Saharan Africa = 1,664

In addition to using web-based searches, we also referred to review papers and sources (e.g., Esquivel-Santoveña et al., 2013) to identify further studies in Africa. Approximately 700 abstracts were selected for review, 126 articles extracted resulting in close to 60 as sources for the analysis of prevalence and determinants.

There are relatively few published reports describing IPV interventions which met the inclusion criteria for this empirical evaluation of prevention or intervention programs addressing partner abuse as at least a component. Specifically, we selected articles published in peer-reviewed journals after 1995 which described programs designed primarily for violence prevention. The study design had to (a) offer an adequate description of the intervention or prevention and sufficient information about the study site and the training protocol, (b) display adequate sample size, (c) a minimum of pre- and posttests, (d) use of a standardized violence outcome measure with demonstrated validity, and (e) the number of participants and attrition data. Articles were identified that assessed prevention and intervention programs focusing on IPV in sub-Saharan Africa. A computer search (MEDLINE, PubMed, JSTOR, PsychINFO, ERIC, and Google Scholar) was performed using key terms (intimate partner violence, domestic violence, perpetrator, sub-Saharan Africa, prevention, intervention, programs); a general Google search was repeated several times with different keywords and which in the first 30 "hits" for relevant content yielded most of the prevention studies contained in the results.

RESULTS

Prevention and Intervention Programs Addressing Intimate Partner Violence

Background. In North America, there are two primary approaches to interventions of IPV: one that exclusively addresses the perpetrators, often mandated to treatment by the courts, and the second addressing the needs of victims, who receive general support services and casework through nonprofit agencies. These programs may use group therapy or triangulate services across different entities and are mainly focused on individual change and recovery. Although perpetrator and victim services both have expanded in the United States since the 1970s, it remains uncertain whether and how effective such interventions are in stopping cycles of partner violence. The perpetrator programs which started, for instance, with Emerge in Boston during the 1977, have since diversified their approach, using various counseling and psychotherapeutic tools (Adams & Cayouette, 2002), yet few have received rigorous evaluation or met adequate study design standards. For example, Gondolf (2004) found that men referred to a “batterer treatment” program across four cities were less likely to be arrested 2 years later for the same crime; on the other hand, only 40% of the participants remained for the duration of the program suggesting self-selection bias. Those published evaluations which do meet minimum evaluation standards often show discouraging results (Babcock, Green, & Robie, 2004). Even programs that implement treatment within the context of probation, which applies sanctions for failing to appear for treatment or reoffending against a partner, show discouraging null results (Feder & Dugan, 2002). Research on the effectiveness of victim services is equally ambiguous. Nevertheless, in one longitudinal study over a period of 8 years, women who stayed in a shelter were more likely to exit the abusive relationship at an earlier time point than abused women who did not receive shelter services (Panchanadeswaran & McCloskey, 2007). The weight placed on experimental evidence and random-controlled designs poses a challenge for evaluations of domestic violence interventions because by the time an *intervention* is needed, as opposed to prevention, there is typically a safety crisis, not unlike patients in need of emergency surgery or treatment. Randomizing subjects in either context to a “waitlist” or “placebo” may also defy ethical standards.

There is a growing literature on prevention programs with youth. Prevention programs have received less close review although a number have shown success in high school settings (Foshee et al., 2004; Wolfe et al., 2003). These programs attempt to promote attitudes *against* intimate violence and enhance gender equality among randomly selected high school students (Wolfe et al., 2003). Findings are encouraging, showing less incidents of abusive behavior in subsequent dating relationships.

The North American models to treat domestic violence are not easily adapted in sub-Saharan Africa in part to the difficulties in translating these across two differing contexts, to the lack of legal and criminal infrastructure to enforce laws against IPV, to the lack of resources for shelters, and to the various problems with introducing

curriculum into secondary schools. Without the undergirding of the criminal justice system, local government policies, and a commitment to reducing violence, positive change is difficult. Although laws against domestic violence have been passed in South Africa, for instance, with the Domestic Violence Act, there is a persistent failure to enforce. With a long history of Apartheid and the use of security forces against the oppressed, the distrust of state-sponsored police remains widespread. In several studies, women have reported a lack of adequate assistance from the police for enforcing protection orders against abusers (Boonzaier & de la Rey, 2003). Moreover, according to these authors, the shelter system in South Africa is heavily under-resourced. Despite such barriers, South Africa in 1990 was among the first countries outside of North America to develop marital violence treatment programs within a marriage and counseling model of intervention known as Families South Africa (FAMSA) established through counseling centers in Johannesburg and further expanded to serve the Western Cape. In the following sections, we will review several programs developed to address IPV or, in some cases, HIV prevention with IPV training as folded in to the substance of the program.

Interventions in Sub-Saharan Africa. The programs developed to prevent domestic violence in Africa are often community-based, with the aim of shifting public opinion to the community level. Recently, more programs have adopted public health approaches to the problem of partner abuse. The North American model of leveraging criminal justice in the service of perpetrator treatment is rare. Programs show varying degrees of success in mitigating the incidence of partner violence. The following programs to be reviewed are Male Norms Initiative (MNI), Safe Homes and Respect for Everyone (SHARE), SASA!, Stepping Stones, Intervention with Microfinance for AIDS and Gender Equity (IMAGE), Your Moment of Truth (YMOT), and Couples Health CoOp (CHC) and Men's Health CoOp (MHC)/Women's Health CoOp (WHC; Table 2). Each of these programs has, to some degree, been successful in reducing the prevalence of partner abuse in sub-Saharan Africa. All programs have published evaluations in peer-review outlets.

The MNI combines group education and community engagement to address gender norms, social expectations, and responsibilities (Pulerwitz & Barker, 2008). The intervention was designed using the expertise of EngenderHealth's Men as Partners (MAP) program and Promundo tested in Brazil and Rwanda among other countries (Peacock & Barker, 2014). Both EngenderHealth and Promundo developed programs that have been successful in varying cultural contexts. The intervention is directed toward males 15–24 years of age. The purpose of the intervention is to promote the development of equitable gender norms and to reduce the risk of negative health outcomes associated with gender norm behaviors. This is done through encouraging critical thought of gender norms associated with behaviors that increase the risk of HIV, STIs, and violence. The program has been found to produce a statistically significant reduction in violence perpetration by the participants. A quasi-experimental study, comparing the impact of the MNI intervention was conducted (Pulerwitz et al.,

TABLE 2. Description and Findings of Intimate Partner Violence Prevention and Intervention Programs

Program/Country/ Reference	Design/Sample	Program Objective	Description of Intervention	Intervention Evaluation
Male Norms Initiative Ethiopia Pulerwitz et al. (2010)	Quasi-experimental Males 15–24 years of age GE (group education) + CE (community education) Pretest (<i>n</i> = 244), posttest (<i>n</i> = 235) CE pretest (<i>n</i> = 287), posttest (<i>n</i> = 251) Comparison posttest (<i>n</i> = 198), posttest (<i>n</i> = 159)	Promote equitable gender norms and reduce risk of HIV.	Group education and community engagement intervention activities Group education: 19 sessions, held once a week, sessions 2 hours each Community engagement: leaflets, newsletters, other materials, music and drama skits, community discussions, condom distribution, International Father’s Day march Carried out in three interventions:	Change in intimate partner violence in past 6 months GE + CE: baseline 53%, end line 38% CE only: baseline 60%, end line 37% Comparison: baseline 38%, end line 37%
			<ol style="list-style-type: none"> 1) Interactive group education with community engagement activities (GE + CE) 2) Only community engagement activities (CE) 3) Comparison, delayed intervention at study end 	

SHARE (Safe Houses and Respect for Everyone) Uganda Wagman et al. (2015)	Existing randomized clusters Men and women 15–49 years of age Four invention clusters ($n = 5,337$) Seven control clusters ($n = 6,111$)	Change attitudes, social norms, and behaviors related to IPV; promote safe HIV disclosure and risk reduction.	Five phases: 1) Community assessment 2) Raising awareness 3) Building networks 4) Integrating action 5) Consolidating efforts	Women Experience of past-year physical IPV Follow-up 1: <i>NS</i> Follow-up 2: (0.79, 95% CI [0.67–0.92]) Experience of past-year sexual IPV Follow-up 1: <i>NS</i> Follow-up 2: (0.80, 95% CI [0.67–0.97]) Experience of past-year forced sex Follow-up 1: <i>NS</i> Follow-up 2: (0.79, 95% CI [0.65–0.96]) Men Perpetration of past-year physical IPV Follow-up 1: (0.80, 95% CI [0.64–1.00]) Follow-up 2: <i>NS</i> Perpetration of past-year sexual IPV Follow-up 1: <i>NS</i> Follow-up 2: (0.81, 95% CI [0.52–1.26]) Perpetration of past-year forced sex Follow-up 1: <i>NS</i> Follow-up 2: <i>NS</i>
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(Continued)

TABLE 2. Description and Findings of Intimate Partner Violence Prevention and Intervention Programs (Continued)

Program/Country/ Reference	Design/Sample	Program Objective	Description of Intervention	Intervention Evaluation
SASA Uganda Abramsky et al. (2014)	Randomized control trial Females and males 18–49 years of age Females ($n = 1,416$) Males ($n = 1,360$)	Prevent violence against women and reduce HIV risk.	Community mobilization inter- vention: carried out in four phases: 1) Start: learning about community, selecting com- munity activist, fostering power within 2) Awareness: helping activist gain confidence, informal activities, en- couraging critical thinking about men's power over women 3) Support: strengthening skills and connections between community mem- bers, joining power with others to support change 4) Action: trying new behav- iors, celebrating change, fostering the power to make positive change	Reduction of acceptability of physical violence by a man against partner: Males (0.13, 95% CI [0.01–1.15]) Females (0.54, 95% CI [0.38–0.79]) Decrease in women's experience of IPV: Past-year physical IPV (0.48, 95% CI [0.16–1.39]). Past-year sexual IPV (0.76, 95% CI [0.33–1.72]).

Stepping Stones South Africa Jewkes et al. (2008)	Randomized controlled trial Females and males 15–26 years of age Females ($n = 1,416$) Males ($n = 1,360$)	Participatory HIV prevention program to improve sexual health through building gender equitable relationships	Participatory learning: critical reflection, role play, and drama. Single sex groups run in parallel, thirteen 3-hour long sessions. Three peer group meetings including males and females. Total program time: 50 hours over 6–8 weeks	Incident of physical or sexual intimate partner violence: 12 months: <i>NS</i> 24 months: <i>NS</i>
IMAGE (Intervention with Microfinance and Gender Equality) South Africa Pronyk et al. (2006)	Randomized trial Any females loan applicant Females and males 14–35 years of age Women who applied for loans from poorest households in intervention communities ($n = 860$) 14–35 years of age, of either sex, living in same house as loan recipient ($n = 1,835$) 14–35 years of age, living in randomly selected households in intervention communities ($n = 3,881$)	Prevention of partner abuse and HIV	Microfinance and structured training: microfinance loans to poorest households HIV training carried out in two phases: Phase 1: Structured training, 10 sessions; 1 session held every 2 weeks Phase 2: Community mobilization	Experience of intimate partner violence in past 12 months: (0.45, 95% CI [0.23–0.91])

(Continued)

TABLE 2. Description and Findings of Intimate Partner Violence Prevention and Intervention Programs (Continued)

Program/Country/ Reference	Design/Sample	Program Objective	Description of Intervention	Intervention Evaluation
Couples Health CoOp (CHC)	Cluster-randomized Males and females	Reduce HIV incidence and risk behaviors.	WHC: evidence-based behavioral intervention; seven core elements based in feminist and empowerment theories and additional content	Relationship conflict: no victimization experienced CHC versus WHC (1.17, 95% CI [0.64–2.12])
Men's Health CoOp (MHC)/Women's Health CoOp (WHC)	6-month follow-up (<i>n</i> = 275)		MHC: paralleled women's inter- vention with elements from Men As Partners program CHC: WHC with the inclusion of aspects of Project Connect	MHC/WHC versus WHC (3.05, 95% CI [1.55–6.00])
South Africa Minnis et al. (2015)			WHC: two 3-hour sessions, four modules (two each session), 1 week apart MHC: two 3-hour sessions, four modules (two each session), 1 week apart and additional content from Men as Partners CHC: two 3-hour sessions, four modules (two each session), 1 week apart	CHC versus MHC/WHC (0.38, 95% CI 0.20–0.74)

Your Moment of Truth (YMOT) Kenya Keller et al. (2015)	Males 15–22 years of age Intervention group (<i>n</i> = 1,543) Standard of care group (<i>n</i> = 293)	Improving male attitudes toward women and increasing likelihood of intervening if witness to GBV	Six 2-hour sessions over 6 week-period: Session 1: introduction to YMOT curriculum Session 2: skills to prepare for YMOT Session 3: intervention Session 4: sexual consent Session 5: responsibility for one's self Session 6: review skills and content	Positive Women Composite Score Intervention Baseline: 17.78 9-month follow-up: 25.05 Standard of Care Baseline: 21.34 9-month follow-up: 20.21

GBV = gender-based violence.

2010). The evaluation compared the three intervention arms over a 6-month period; community engagement and group education, community engagement, and a control group. Surveys were administered to young men prior to the intervention ($n = 729$) and 6 months after the intervention was completed ($n = 647$). The evaluation showed a decrease in IPV perpetration in both intervention arms (Pulerwitz et al., 2010). The evaluation findings revealed that community-based interventions focusing on gender norms are associated with reduced partner violence, lower risk of HIV and other STIs, and can lead to healthier relationships. These findings also suggest that combining group education sessions and community engagement efforts may be more effective in changing gender-related attitudes and reducing partner violence than using just one approach alone.

SHARE is a community-based intimate partner intervention conducted by Rakai Health Sciences Program in Uganda (Wagman et al., 2015). The SHARE project was designed by adapting IPV prevention strategies from Raising Voices and Stepping Stones (Wagman et al., 2015). The SHARE project works in partnership with community residents, local leaders, and professionals in Rakai to prevent and mitigate gender-based violence. SHARE's aims are accomplished through changing attitudes and social norms to reduce partner abuse (i.e., sexual and physical) and the incidence of HIV and was developed using an ecological framework: The intervention addresses compelling factors of partner abuse and HIV transmission at the individual, relationship, and societal levels. The SHARE intervention is made of five phases and supporting strategies. The five phases include the following: Phase 1, community assessment; Phase 2, raising awareness; Phase 3, building networks; Phase 4, integrating action; and Phase 5, consolidating efforts. Physical and sexual partner abuse has been found to be significantly reduced after participation in the SHARE intervention. A cluster-randomized trial was conducted in Rakai, Uganda, from 2005 to 2009. Four intervention clusters received the SHARE intervention and enhanced HIV testing and linkage to services ($N = 5,339$), and seven control arm clusters received standard of care HIV services ($N = 6,112$). The SHARE project evaluation found a decrease in women's experiences of physical and sexual IPV but no change in men's reported perpetration of these outcomes (Wagman et al., 2015). Because the SHARE project focused predominantly on adults, these findings can shed light on the importance of addressing societal norms and behavior change at a younger age.

SASA! which means *now* in Kiswahili, is a community mobilization intervention developed to prevent violence and reduce HIV risk behaviors that was started by Raising Voices in Uganda (Abramsky et al., 2014). This intervention was designed to work with a broad range of stakeholders to change community attitudes, norms, and behaviors that result in gender inequality, violence, and an increased risk of HIV (Abramsky et al., 2014). The SASA! program encourages participants—both female and male—to critically consider the impact that power imbalance has on violence against women and HIV risk for women. There are four phases to SASA!, and each phase focuses on a different concept of power: (a) *power within*, (b) *power over*,

(c) *power with*, and (d) *power to*. SASA! has been implemented by different groups in the following countries: Botswana, Burundi, Ethiopia, Kenya, Malawi, Rwanda, South Sudan, Tanzania, Uganda, and Zambia (Raising Voices, 2013). Participation in the SASA! program has been found to shift attitudes of social acceptance of partner violence and acceptability of the refusal of sex by women (Abramsky et al., 2014). From 2007 to 2012, a pair-matched cluster-randomized controlled trial was conducted in eight communities (four intervention sites and four control sites) in Kampala, Uganda (Abramsky et al., 2014). Cross-sectional surveys of a random sample of community members were conducted at baseline ($n = 1,583$) and 4 years after the implementation of the intervention ($n = 2,532$; Abramsky et al., 2014). The intervention was associated with significantly lower social acceptance of IPV among women and men (Abramsky et al., 2014). Men who participated in the intervention reported significantly lower past year incidence of concurrent sexual partners than men in the control communities (0.57, 95% CI [0.36–0.91]; Abramsky et al., 2014). In addition, program participants were found to experience lower rates of physical and sexual partner abuse.

Stepping Stones is a participatory program that takes on gender, HIV, communication, and relationship skills (Jewkes et al., 2008). The program is gender inclusive, for those 11 years of age and up. Stepping Stones uses a human rights approach. Participants use their personal experiences to critically examine issues such as gender inequalities and violence, STI and HIV reduction, and traditions. Through this process, solutions relevant and congruent with the participants' contexts are devised and implemented. Stepping Stones is delivered in its original form (Welbourn, 2005) and adapted for use in varying contexts. The original and adapted versions are currently used in many countries including Angola, Botswana, Burkina Faso, Ethiopia, Kenya, Malawi, Mali, Namibia, Nigeria, South Africa, and Tanzania (Wallace, 2006). Results from a randomized controlled trial of 35 rural South African villages as controls and 35 introducing the Stepping Stones intervention showed a reduction in sexual and violent behaviors among men (Jewkes et al., 2008). Specifically, more men adopted correct condom use, and fewer men reported any transactional sex or concurrent partners in the Stepping Stones arm of the study after 12 and 24 months. In qualitative interviews, men reported an awareness of IPV and sexual aggression, and some reported eliminating these behaviors in their interactions with women. Women showed 15% lower HIV infections in the Stepping Stones arm than in the control 2 years later; disease reduction appeared to be unrelated to a concomitant change in their own sexual behavior. One interpretation is that the men in their village changed their own high-risk activity which in turn diminished women's exposure.

IMAGE is a microfinance program that is combined with an HIV and gender issues curriculum (Pronyk et al., 2006). The microfinance component of the program is overseen by the Small Enterprise Foundation (SEF; Global Violence Prevention, 2014). The training program uses the Sisters-for-Life (SFL) adapted curriculum. SFL is a participatory learning and action-based curriculum (Global Violence Prevention, 2014). The aim of the intervention is to economically empower women to reduce

susceptibility to partner abuse through microfinance loans and training to increase confidence and skills. Phase 1 curriculum includes gender roles, cultural beliefs, relationships, communication, partner abuse, and HIV. Phase 2 is a community mobilization phase. Participation in the IMAGE program has been found to lead to women's empowerment and a reduction in partner abuse (Pronyk et al., 2006). The evaluation included 1,409 women and compared three randomly selected clusters in rural parts of South Africa (Pronyk et al., 2006). One arm (four villages) received the full IMAGE program with microfinance and education about gender equity, a second with microfinance alone, and a third without any intervention. Outcome measures after 2 years included economic well-being, empowerment, IPV, and HIV risk behavior. Only the IMAGE group yielded significant effects across the domains relating to women's empowerment, IPV, and HIV risk behavior (Kim et al., 2009).

YMOT is a program using curriculum focused on improving adolescent boys' attitudes about partner violence and to promote the "bystander" response to violence if they witness it enacted against a woman (Keller et al., 2015). The bystander response includes intervening or notifying someone when an attack is occurring, and some training programs especially have met with success in the United States and other countries (Banyard, Plante, & Moynihan, 2004; Gidycz, Orchowski, & Berkowitz, 2011). YMOT is a school-based curriculum to increase awareness of gender role norms and violence (Keller et al., 2015) directed toward young men (ages 15–22 years). This intervention program included male high school students in urban slums of Nairobi. A prospective cohort of 1,250 adolescent boys from five impoverished districts of Nairobi participated in the 6-week program (Keller et al., 2015). Each participant attended six 2-hour sessions designed to raise boys' awareness of the social stereotypes that promote gender-based violence. Data on attitudes and behaviors relating to the gender roles of girls and women were collected at baseline ($N = 1,250$), at completion of intervention ($N = 1,086$), and 6 months after the completion of the intervention ($N = 889$). Attitudes toward girls and women improved significantly after the intervention and were sustained 1 year later (Keller et al., 2015). While at baseline, 42.2% of participants endorsed the statement "all women should be treated with respect"; more (79.1%) agreed with the sentiment after training ended. Moreover, participants were more likely to intervene if they witnessed interpersonal violence. At the end of training, 73% of the intervention youth actually self-reported trying to stop or discourage a physical threat made to another person in contrast to 33% of those receiving no intervention indicating strong support for bystander training as a mechanism of social change. There is the possibility of "demand characteristics" influencing students' responses on these and other questions at follow-up.

The CHC and WHC/MHC program is a couple's intervention program aimed at reducing the incidence of HIV and risk behaviors. To accomplish this outcome, the program focuses on improving gender equity and communication (Minnis et al., 2015). The program uses the WHC intervention as its foundation. The WHC is an evidenced-based behavioral intervention grounded in feminist and empowerment theories. The MHC component of the program is parallel to the WHC but also contains elements

taken from the MAP program. CHC uses the WHC intervention and elements from the couples-based intervention for HIV from Project Connect. Each of the intervention components are carried out in two 3-hour sessions, held 1 week apart. Component was composed of four modules, with two being delivered each session. The CHC and MCH/WCH intervention lead to increases in women's self-reported relationship power (Minnis et al., 2015). The cluster-randomized field evaluation was performed in the Western Cape (South Africa) with three randomized arms: (a) the WHC intervention for women with their partners receiving HIV testing, (b) the WHC to women and the MHC delivered separately to partners, and (c) a mixed program including features of both the WHC and MHC provided to couples together at the same time. The sample size was 295 couples, although it should be noted that 71% were not coresiding with their partner at the time of the intervention. How generalizable the results are to married couples remains uncertain. The most compelling finding was the comparison of the couples from each arm after a 6-month follow-up: Those who participate jointly in the MHC/WHC—in which men received as intensive interventions as the women simultaneously—were largely violence-free at follow-up (78.6%) in contrast to couples in which the same intervention was given separately (60%) or only to the women (60%). The odds of having a lower violence score were high ($OR = 3.03$) when the intervention involved providing the program to couples conjointly. The findings suggest that perhaps a “third” variable is created in joint sessions that enhances understanding within the relationship when the various issues from the intervention are presented.

DISCUSSION

Intimate partner abuse is a widespread problem throughout most of sub-Saharan Africa with some of the highest global rates appearing in Southern and East Africa. Determinants of partner abuse include individual risk factors often cited in studies outside of Africa such as a past history of child abuse and men's or women's drinking. Cultural values, the place of women in society, poverty and the lack of education, and the weakened rule of law in the countryside all magnify the risk for family violence emanating from cultural and societal pressures intersecting with personal vulnerabilities. Beliefs justifying violence against wives are commonplace. In Uganda, Kenya, and other countries, both men and women endorse the use of physical punishment against an “errant” or “rebellious” wife. In some communities, marriage arrangements which include a brideprice or forced early marriage bolster the view of women really as chattel for ownership and transfer. Throughout sub-Saharan Africa, while polygamy has been waning, men continue to exercise their prerogative to sexual freedom by enlisting multiple sexual partners even while married or cohabitating with a steady partner. Infidelity and multiple partners are associated with the expression of IPV in Africa and play a role in the AIDS epidemic. Perhaps the best evidence that multiple partners have exacerbated the epidemic in Africa is the retreat from infidelity in Uganda resulting in enormous reductions in the incidence of HIV.

Some of the surveys conducted in sub-Saharan Africa find that both men and women admit to physically abuse their partners. Perhaps the most disturbing pattern of physical aggression was found in the adolescent survey of South African youth: 26% of the girls and 25% of the boys had engaged in physical abuse such as slapping or pushing with an intimate partner (Swart, Seedat, Stevens, & Ricardo, 2002). In a 32-country survey, Straus (2008) found that both male and female college students equally admitted to wanting to control a romantic partner. Symmetry in intimate aggression is commonly reported among teenage dating partners. Although the aggression may appear mutual, girls report more fear (Hamby & Turner, 2013). The fact that girls are engaging in physical altercations so early in their sexual lives is a harbinger for escalation and real potential injury in their future. When girls who hit their boyfriends in secondary school eventually marry, for instance, they may find that slapping their husband culminates in their own hospitalization. In fact, the implication of being a victim of partner abuse is different for boys and girls as they mature, although we lack a full developmental portrait of relationship violence and its changing meaning over time.

The sheer frequency of men's abuse against partners in South Africa is alarming: Whether women initiate the altercation or fight back, there is little question that many more women will suffer serious injuries than will men from partner abuse. Among the 47% of Cape Town working class men who admitted that they had hit their partner or wife during the past year, 21% reported that their aggression resulted in their partner's hospitalization (Abrahams et al., 2006). Sexual assault is overwhelmingly a threat to women rather than to heterosexual men with the potential associated burdens of unwanted pregnancy, HIV, STIs, and psychological harm. Men who have sex with men, on the other hand, are subject to the heightened risk of rape and the health and psychological toll such experiences impose (Jewkes et al., 2011). It is important to recognize that IPV and sexual assault derive from pervasive gender inequality in much of sub-Saharan Africa restricting girls and women in education, access to healthcare, decision making in marriage and divorce, fertility, and equal employment. These barriers to women's development impose a cost to societies in Africa and elsewhere in the world. The future of these African countries, their prospects for economic growth, hinge on how swiftly such barriers are lifted (Schultz, 1999).

Individual treatment is the widespread approach to ending domestic violence in the United States and other Western countries—such an approach is far less common in the African attempts to resocialize adolescents and adults to abandon violence in intimate relationships. The fact that there is evidence for aggression on the part of both women and men indicates that treatment approaches should focus on all adults as potential perpetrators to mitigate relationship violence. However, much more information is needed about the context of partner violence, including who initiates and for what reasons. In particular, it is important to recognize the cultural and ecosocial differences in sub-Saharan Africa and elsewhere to fully understand the context and the meaning of partner abuse in a given milieu. In one study, nurses were selected to intervene and provide brief counseling for abuse victims, yet they held

attitudes highly critical of the victims, reflecting the “blame the victim” social bias (Kim & Motsei, 2002). Only after therapeutic interventions with the nurses themselves especially around the topics of gender bias in their own lives were they effective with clients.

It is noteworthy that sexual assault, domestic violence, and FGM are outlawed by governments throughout sub-Saharan Africa, yet the ambient attitudes and values justifying these practices appear to be entrenched. The interventions we have reviewed here show that change is possible and that both attitudes and behavior are modifiable with education and community-supported programs. All of the programs reviewed yielded positive findings although not in every measured outcome. The programs were initiated with the support of local community leaders in almost all cases; they drew people together to work through and discuss stereotypes, behaviors, and gender-related issues surrounding violence and sexuality so the sessions were inherently reinforcing through social bonds, and they acknowledged negative stereotypes and openly discussed sex, HIV, and abuse—all topics which are typically taboo in African communities. Of course, the open recognition of these issues in a public forum defuses the secrecy that lends strength to harmful practices. The programs varied in their targets: IMAGE was directed toward women exclusively, and the MNI or YMOT were designed for adolescent boys and young men. Programs designed for both men and women often yield different findings by sex. For instance, SHARE yielded significant differences among women only, with fewer women reporting victimization at follow-up, whereas Stepping Stones documented extensive change in men’s self-reported sexual behavior and IPV but few to no parallel difference in women’s reports. On the other hand, at follow-up, women in the intervention arm were 15% less likely to test positive for HIV suggesting that the behavioral changes recorded in the men may be translating to lower risk for the women because they were from the same villages. The studies all used randomized controlled trials, controlling for allocation bias, and the researchers were vigilant about other potential sources of bias in the conduct of their studies. Given the challenges in implementing such community-based programs and instigating cognitive-behavioral change, the results are highly encouraging especially because they derive from different programs based in different countries. Nevertheless, the failure of many government entities in Africa to respond to IPV and sexual assault create barriers to social change. Palermo, Bleck, and Peterman (2014) analyzed the responses of more than 284,000 women in countries around the world to uncover the potential base rate of reporting to hospitals, police, or courts, finding that as many as 40% of women worldwide disclosed abuse with only about 2%–4% reporting to formal entities. The vast underreporting of violence to authorities allows governments to withhold resources addressing the problem and makes it difficult to find acceptance for a problem that remains in the shadows.

The Institute of Medicine submitted a report with recommendations for improving the general database on psychosocial interventions, and although the committee’s focus was psychological and substance abuse, their proposed framework might guide the field of IPV prevention and intervention in sub-Saharan Africa.⁵

Among their key recommendations for those building on psychosocial interventions are to

- Build the evidence base on the efficacy of psychosocial interventions
- Explain exactly how the intervention produces positive change
- Perform systematic reviews to elucidate the elements of interventions that are critical
- Develop quality measures of the outcomes of the interventions
- Develop guidelines for implementing psychosocial interventions in practice

The field has made progress in fulfilling this agenda and certainly the first criterion has been met. How the interventions actually result in change remains unknown in most cases, and strengthening the theoretical foundation underlying the clinical process would be useful. One issue in comparing study results is the measurement of outcomes. As is evident in this review, researchers use different instruments and constructs to conceptualize IPV, making comparisons inexact. To this end, it may be useful to expand qualitative research on the context of IPV in Africa, identify the “readiness to change” among perpetrators, and the challenges inherent in the work with the aim of providing specific guidelines for replication. IPV has declined on a population-based level in the aftermath of interventions, laws, and changing community norms in many countries including the United States; in sub-Saharan Africa, such change through either individual treatment approaches or societal reform could stem the devastating HIV epidemic in addition to building a safer and more humane society overall.

NOTES

1. The 24 sub-Saharan countries include Angola, Benin, Botswana, Burkina Faso, Chad, Cameroon, Ethiopia, The Gambia, Kenya, Ghana, Lesotho, Madagascar, Malawi, Mali, Mauritius, Mozambique, Namibia, Nigeria, Senegal, South Africa, Tanzania, Uganda, Zimbabwe, and Zambia (Hausmann, Tyson, & Zahidi, 2009). This paper only includes those countries for which the evidence meets the scientific criteria for inclusion.
2. These reports have been described in the local news (Dahir, AL. [2012]. *In Kenya, violence against men rises*. Retrieved from http://www.upi.com/Top_News/Special/2012/06/08/In-Kenya-violence-against-men-rises/81041339152827/)
3. AIDS.gov. (2015). *Global statistics*. Retrieved from <https://www.aids.gov/hiv-aids-basics/hiv-aids-101/global-statistics/index.html>
4. World Health Organization. (2013). *Female genital mutilation*. Retrieved from <http://www.who.int/reproductivehealth/topics/fgm/prevalence/en/>
5. Institute of Medicine, July, 2015 (National Academy of Medicine) report on psychosocial interventions. *Psychosocial Interventions for Mental and Substance Use Disorders: A Framework for Establishing Evidence-Based Standards* (2015). Retrieved from <http://www.nap.edu/read/19013/chapter/1>

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