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Publication details, including instructions for authors and subscription information:

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Published online: 23 May 2013.

To cite this article: Navindhra Naidoo & Lubna Nadvi (2013): Risk factor management and perpetrator rehabilitation in cases of gender-based violence in South Africa: Implications of salutogenesis, Agenda: Empowering women for gender equity, DOI:10.1080/10130950.2013.801196

To link to this article: <http://dx.doi.org/10.1080/10130950.2013.801196>

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Risk factor management and perpetrator rehabilitation in cases of gender-based violence in South Africa: Implications of salutogenesis

Navindhra Naidoo and Lubna Nadvi

abstract

It has become an established socio-political reality that South Africa has evolved into a very violent society, the manifestations of which are seen over the last two decades, despite having transitioned to a post-apartheid context. A woman is reported to be killed every eight hours in South Africa (Sapa, 'MRC says 3 women a day killed in SA', 7 November 2012). The interpersonal nature of the violence is suggestive of societal fragmentation particularly where the perpetrator is known to the victim and where there are fatal or protracted consequences of abuse.

The phenomenon of gender-based violence has reached virtually epidemic proportions and continues to manifest in various ways, such as domestic violence, rape, sexual assault, sexual harassment and the murder of intimate partners. As perpetrators or potential perpetrators of gender-based violence, South African men of have become central to the perpetuation of the problem and it is crucial that they be targeted for intervention measures. The health promotion model provides for interventions aimed at primary prevention, early detection and tertiary care or rehabilitation. Whilst tertiary interventions may be too little too late, the early detection interventions are a logical next step to advocacy and awareness campaigns. Whilst rehabilitation interventions are reactive, early detection fosters agency and reflection and is by design pro-active.

This *Briefing* explores how a structured process of targeted interventions for men who may be prone to committing acts of gender-based violence through the model of salutogenesis (creation of wellness), as opposed to models of pathogenesis (creation of illness), could potentially become a key aspect of the solution towards attempting to bring down the overall rates of violence across the national spectrum. It draws on experiential work and theoretical knowledge that is resonant in various practitioner (and researcher) contexts such as the Advice Desk for the Abused, a non-governmental organisation (NGO) that deals with crisis intervention. Current practices are problematised and the implications of the salutogenesis model are presented in the context of gender-based violence.

keywords

Gender-based violence perpetrator rehabilitation, gender-based violence, salutogenesis, sense of coherence, health promotion

The phenomenon of gender-based violence (GBV) has reached epidemic proportions in South Africa. Globally, it satisfies the case-

definition for 'pandemic' (World Health Organisation, 2006), but yet national institutional responses do not rival that of an

Agenda 2013

ISSN 1013-0950 print/ISSN 2158-978X online

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<http://dx.doi.org/10.1080/10130950.2013.801196>

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pp. 1–10

briefing

infectious disease outbreak. It continues to insidiously manifest in various ways, with the perpetration of domestic violence, rape, sexual assault, sexual harassment and the murder (one every six hours in 1999) of intimate partners – the highest femicide rate world-wide (Matthews *et al*, 2004). Ten years later, a two hour reprieve was achieved as “one woman is slain in every eight hours” in South Africa (Sapa, ‘MRC says 3 women a day killed in SA’, 7 November 2012). The Medical Research Council (MRC) also warns that whilst the number of femicides declined overall, the proportion of women killed by their husbands, boyfriends or same-sex partners rose from 50.3% in 1999 to 57.7% in 2009. There was only a marginal improvement in convictions, where charges were laid and there was “no evidence that police improved investigations into crimes against women” (*ibid*).

As perpetrators or potential perpetrators of GBV, South African men of all demographic profiles have become central to the perpetuation of the problem of GBV and it is crucial that they be targeted for intervention measures. The nature of GBV suggests under-reporting and reporting that may be biased towards the nature of the offence, the resources of the victim, fear of reprisals or secondary victimisation and self-blame (Statistics South Africa, 2011). Having some knowledge of who constitutes the ‘perpetrator of GBV’ is arguably very helpful in seeking solutions and intervention strategies, whether for the short-, mid- or long-term. Having an empirically ill-defined perpetrator and victim population does not assist in the generalisability and efficacy of current and past rehabilitation methodologies.

The health promotion model provides for interventions aimed at primary prevention, early detection and tertiary care or rehabilitation.

In the South African context, the practice of certain cultural beliefs have led to particular forms of GBV which may not be common elsewhere, such as *ukuthwala* (kidnapping for marriage purposes) and so-called ‘corrective rape’ (of lesbian women). Hence responses to these forms of GBV have to take into account that tradi-

tional approaches applied elsewhere may not be transferable to the local context. What is therefore required is a shift away from the conventional methodology of intervention and rehabilitation, and the incorporation of several models to achieve some degree of effectiveness. The health promotion model provides for interventions aimed at primary prevention, early detection and tertiary care or rehabilitation. Tertiary and rehabilitative approaches entail reactive interventions that occur after the GBV act has been committed. It is argued that the early detection interventions are a logical next step toward advocacy and GBV awareness campaigns because early detection fosters agency and reflexivity and is pro-active.

We suggest in this *Briefing* that the modification of the traditional health promotion model be interrogated in some greater detail to allow for the ‘reconceptualisation’ and indeed re-positioning of rehabilitation methodologies, such that they aim for intervention before a perpetrator commits an act of GBV or becomes a serial offender. There are therefore two central arguments. Firstly, that the status quo, as regards perpetrator rehabilitation, is morally, resource and outcome inefficient. Secondly, that salutogenesis (a health promotion theory of wellness creation) provides a point of departure and perhaps even arrival for an alternative conception of *post-facto* perpetrator rehabilitation, toward earliest prevention of violence perpetration or, at least, risk factor management. There is in essence, no contradiction, in that rehabilitation is in effect tertiary (*post-facto*) prevention. This *Briefing* intends to shift the focus leftward toward primary and secondary prevention. It does not intend a deep gender analysis.

The problematisation of current interventions

In the early phase of the post-apartheid transition to democracy and democratic consolidation initiatives at a national level, it was assumed that introducing various forms of legislation and policy prescriptions would be a solution to the issue of gender inequality and historical discrimination and violence against women, children and other

vulnerable groups. Thus, the introduction of the Domestic Violence Act (No. 116 of 1998) and the Commission for Gender Equality. The Criminal Law (Sexual Offences and Related Matters) Amendment Act (No. 32 of 2007) amongst other legislation has become central to the process of seeking remedies to the problem of GBV and violence in general. However, as the 2011 crime statistics (Statistics South Africa, 2011) will attest to, these laws and policy frameworks, have not managed to substantively address the social affliction of GBV in post-apartheid South Africa, nor do they seem to help to reduce the incidence of the problem. The Truth and Reconciliation Commission focused on gross violations of human rights (Ramphela, 2012), yet, it could not reconcile the social inequity that feeds gender inequity and the resultant GBV. Legislation, by design, is intended to promote justice, protect victims and punish offenders; it is not principally designed to change behaviour.

Recognising the potential futility of current interventions, in the absence of permanent solutions, is a critical first step allowing reconceptualising of GBV interventions. The emphasis on crisis intervention for victims of abuse presents a reactive, *albeit*, necessary response. The high prevalence of abuse, suggests that we may never be able to satisfy the burden of victims given current resources and the mostly symptomatic relief that is provided to both victims and perpetrators whose experience of GBV, seem problematically to feed the propensity for more violence. The social constructions of abuse suggest a form of 'behaviour communicability' where high levels of direct or indirect exposure to abuse (as victim or perpetrator) is likely to result in perpetuation of abusive or victim behaviours by those exposed. In epidemiological terms (Katzenellenbogen, Joubert and Abdool-Karrim, 1999), the societal, health or economic burden of abuse is only mitigated if interventions target the safety and development needs of communities in which abuse is prevalent (where there are existing cases), if early detection and appropriate response measures are universal and if primary prevention measures result in a critical reduction in incidence (new cases). The critique of current professional

and community practice in GBV intervention is that it is insufficient to impact on the incidence of GBV: *post-facto* interventions prevail with gender violence unabated.

Perpetrator rehabilitation: efficacy is minimal

The perceptual danger with the term 'perpetrator' is that it limits the focus to the offending '*act-or*'. It distracts from all that 'perpetuates' a violent society. The unabated incidence and high prevalence (Statistics South Africa, 2011) suggest a nation of GBV victims; and by rational conjecture, a nation of perpetrators. This dichotomy cannot hold, as the social, health, economic and justice system cannot cope with the criminalisation and victimisation of a significant part of society. We therefore propose a parallel non-criminal and non-pathological approach to rehabilitation. The limitation of perpetrator rehabilitation is that because it is reactive it does not target potential perpetrators. Moreover, evidence suggests it has not provided the success promised (Babcock, Green and Robie, 2004).

The limitation of perpetrator rehabilitation is that because it is reactive it does not target potential perpetrators.

In a meta-analytic review examining the findings of 22 studies evaluating the treatment efficacy of therapeutic interventions for domestically violent males (beyond legal interventions), only a minimal impact was found (Babcock, Green and Robie, 2004). According to the most prominent pro-feminist psychoeducational approach, the Duluth model (Pence and Paymar, 1993):

"...the primary cause of domestic violence is patriarchal ideology and the implicit or explicit societal sanctioning of men's use of power and control over women...group facilitators lead consciousness-raising exercises to challenge the man's perceived right to control or dominate his partner. A fundamental tool of the Duluth model is the 'Power and Control Wheel', which illustrates that

violence is part of a pattern of behaviour including intimidation, male privilege, isolation, emotional, and economic abuse, rather than isolated incidents of abuse or cyclical explosions of pent-up anger or painful feelings. The treatment goals of the Duluth model are to help men change from using the behaviours on the Power and Control Wheel, which result in authoritarian and destructive relationships, to using the behaviours on the 'Equality Wheel', which form the basis for egalitarian relationships" (Babcock, Green, and Robie, 2004: 1026).

Alternately, the cognitive behavioral batterers' approach to interventions (Adams, 1988):

"...tend to make violence the primary focus of treatment. Since violence is a learned behaviour, nonviolence can similarly be learned according to the cognitive-behavioural model" (Babcock, Green, and Robie, 2004: 1026).

According to this approach, violence continues for several reasons including because it functions for the abuser as a means of achieving "...victim compliance, putting a temporary end to an uncomfortable situation..." (Babcock, Green, and Robie, 2004: 1026), and gives the abuser a sense of power and control (Sonkin, Martin and Walker, 1985). The pros and cons of violence and anger management and techniques to promote awareness of alternatives to violence are elaborated by the proponents of these approaches. Notwithstanding the above, these interventions were designed without an evaluation framework.

evidence of the effectiveness of domestic violence programmes, to the point of declaring best practice, is far from conclusive

The review of therapeutic interventions found no significant difference between Duluth-type and cognitive-behavioural treatment using either police or victim reports as the measure of recidivism (repetition of offences by offenders). A 5% to 15% decrease in recidivism was documented between those that took part in an intervention and those that did not. In 2005, a review of 10 studies investigated the effectiveness

of court-mandated domestic violence interventions in the United States (Feder and Wilson, 2005). Official reports of repeated domestic violence showed a modest benefit for those who received treatment compared to those who had not. When victim reports were the outcome, no difference was found. Another review of nine rigorous evaluations of domestic violence treatment programmes (Washington State Institute for Public Policy, 2006) concluded that domestic violence rehabilitation programmes had not yet made a difference to the rate of recidivism. Further evidence of the absence of a strong evidence base for domestic violence interventions, were the results of a 2009 review of seven domestic violence perpetrator treatment studies (Stover, Meadows and Kaufman, 2009). The evidence from these studies suggest that perpetrator interventions have limited effect on repeated violence, with most studies demonstrating minimal or no benefit, above the no treatment group.

These studies caution against an over-reliance on perpetrator rehabilitation alone. The rehabilitative ideal still needs to prove effectiveness in changing abusive behaviour (Bowen, Brown and Gilchrist, 2002). The above studies demonstrate that the evidence of the effectiveness of domestic violence programmes, to the point of declaring best practice, is far from conclusive. What options should we then consider in the developing world where monitoring systems are evolving and where interventions are also less accessible to victims and perpetrators?

The pursuit of societal wellness

In the absence of strong empirical evidence directly guiding GBV interventions, salutogenesis (the creation of wellness as opposed to the creation of pathology) is a useful theoretical orientation that has implications that deviate from the criminal justice or pathological responses of present interventions (Antonovsky, 1996; Mittelmark, 2008). In an emergent democracy, such as South Africa, a focus on human rights dominates the socio-political discourse to the extent that it may often be reduced to rhetoric. Having a history fraught with human rights violations requires a future characterised by human rights entrenchment, protection and realisa-

tion. The promise of constitutional guarantees, however, does not always translate to an improved lived reality. Constitutional realisation is confounded further by threats to the doctrine of separation of powers and inefficiencies at the level of socio-political, economic and criminal-justice institutions in the context of neoliberalism (Naidoo, 2010). As Norman *et al* (2010: 1; see also 2007) have argued:

“Violence is an important direct and indirect cause of health loss and should be recognised as a priority health problem as well as a human rights and social issue.”

Addressing interpersonal violence as a burden of disease (*ibid*) requires mitigation and reduction of both cause and consequence.

Theories, such as the model proposed by Antonovsky’s salutogenesis (Antonovsky, 1996), provide relief by shifting the discourse leftward, toward *solution delivery* (upstream) rather than *service delivery* (downstream) – an ill-executed mantra of the public service. Servicing a problem does not make it go away; it is an attempt at attenuation. The service delivery protests make the case for discontent at the level of service delivery alone.

Van den Broucke, in his editorial of *Health Promotion International*, has emphasised the need to work with the specific contexts in question and affirms Antonovsky’s paradigm as corroboratory toward a ‘bird’s eye’ perspective:

“However, while theories extract their explanatory and predictive power from the fact that they generalise across specific situation and contexts, which makes them very useful to guide decision-making, their application to a specific programme or research question always requires the reverse process of contextualising” (Van den Broucke, 2012: 145).

The following discussion will look at perpetrator rehabilitation through the lens of salutogenesis, which, as a model, lends itself to further accommodation and adjustment, especially in the South African context. As a theory, it presents epistemological congruence with social constructivist perspectives of GBV (Alvesson and Sköldbberg,

2009). This congruence enhances the validity of the proposed intersections that follow.

Notwithstanding the legal transgressions, GBV manifests in poor health outcomes (World Health Organisation, 2006; Aschman, Meer and Artz, 2012). It is not in dispute that gender-based violence violates human rights on many levels. It is also not in dispute that any human rights violation must be met with both contempt and redress. As a gender-sensitive law, the Domestic Violence Act (No. 116 of 1998) (Republic of South Africa, 1998), is intended to protect victims of abuse, promote justice and punish perpetrators. However, the poor prosecution rate for rape, for example, renders domestic violence one of the ‘safest crimes’ to commit in South Africa. Our incidence of sexual violence crimes against both women and children suggest an unacknowledged gender civil war (Moffett, 2001). In *A Country at War with Itself*, Altbeker (2007) uses the war analogy to advocate for stronger criminalisation and punitive measures in the context of a dysfunctional criminal justice system. Collins, in *SA Crime Quarterly* (2009) suggests alternative approaches to Altbeker. Whilst appropriately representing the magnitude of the problem, this does little to provide hope. Hence, it is proposed that the following reconceptualisation of perpetrator rehabilitation is warranted.

The attainment of well-being, health and functioning are societal as much as they are individual goals.

The attainment of well-being, health and functioning are societal as much as they are individual goals. The assumption is that the perpetrator, as a constituent member of the society, has an interest in attaining these goals and it is through the mutual pursuit of wellness that rehabilitation may be successful. This wellness implies a life free of interpersonal violence. Antonovsky tried to find the solution to the question why some people, regardless of major stressful situations and severe hardships, stay healthy, while others do not. How do people manage their inability to control their life? The answer was formulated (see Figure 1) in terms of “Sense of coherence” and “General resistance resources” (Antonovsky, 1996: 15). The sense of coher-

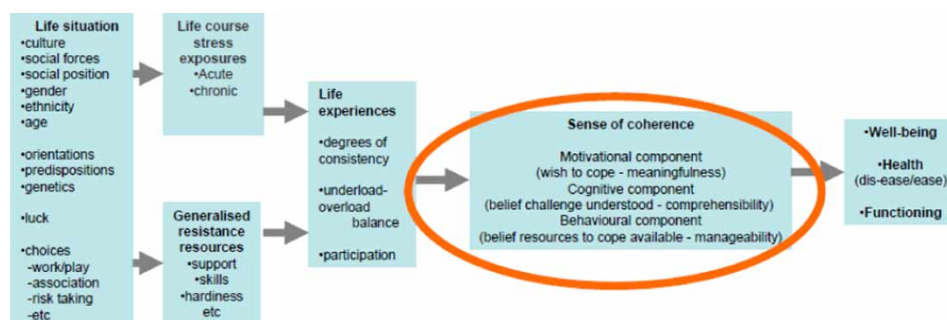


Figure 1. The salutogenic model to guide health promotion [adapted from (Antonovsky, 1996; Mittelmark, 2008: 12)]

ence refers to an enduring attitude and measures how people view life and, in stressful situations, identifies and draws out their generalised resistance resources to maintain and develop their health and a life free of violence, fear or aggression. The generalised resistance resources are, for example, money, intelligence, self-esteem and preventative health orientation, social and cultural capital all of which could be resources that are a prerequisite of GBV prevention. People with the resistance resources at their disposal have a better chance to deal with the challenges of life (Eriksson and Lindström, 2007).

When the person regularly experiences the availability of generalised resistance resources, a strong sense of coherence develops. The sense of coherence affects the overall quality of an individual's perception of the stimuli that impact on him or her (Antonovsky, 1996). The stimuli are experienced as *comprehensible* being the cognitive sense of the eroding nature of violence, *manageable* relating to the factors that nurture internal/own control (toward non-violence, equality and mutual respect) and control by legitimate others (e.g. spouse, friends, formal authorities, god), and motivationally *meaningful* – being welcome challenges that are worth investing oneself in and engaging with. In turn, persons with a strong sense of coherence will have the ability to bring into play the generalised resistance resources available to them. The resultant display of self-efficacy and low stress exposure results in physical well-being and social functioning.

The sense of coherence is construed as the product of having grown up in a particular social structure, culture and historical

period, as well as of idiosyncratic events in the individual's own life (Antonovsky, 1996: 15). These sense of coherence dimensions constitute the origins of health and foster resilience, coping, satisfaction and autonomy – dimensions that are consistent with the WHO definition of 'Quality of Life' (QoL) and positive mental health (Kovess-Masfety, Murray and Gureje, 2005).

Enhancing the sense of coherence

The ambivalence of violence perpetration as serial yet antisocial behaviour is suggestive of incoherence in the life being lived. In the family context, a parent's sense of coherence has a direct effect on the child's sense of coherence (Togari *et al*, 2011). In a review of 458 scientific publications and 13 doctoral theses on salutogenesis (Eriksson and Lindström, 2007), 32 papers had the main objective of investigating the relationship between sense of coherence and Quality of Life (QoL). The findings indicated a strong relationship between them with positive implications for constructions of health:

"The SOC [Sense of Coherence] seems to have an impact on the QoL; the stronger the SOC, the better the QoL. Furthermore, longitudinal studies confirm the predictive validity of the SOC for a good QoL. The findings correspond to the core of the Ottawa Charter (World Health Organisation, 1986) – that is, the process of enabling people to live a good life. Therefore, a certain possibility to modify and extend the health construct is becoming discernible, implicating a construct including salutogenesis and QoL.

The SOC concept is a health resource, influencing QoL" (Eriksson and Lindström, 2007: 938).

Success in GBV prevention is only probable if theory, research and practice in creating conditions for health converge (Van den Broucke, 2012). These are not mutually exclusive domains and the complexity of intersectionality between and within disciplines is acknowledged (McCaul, 2005). The major appeal of this model of health promotion is that it has the potential to impact on perpetrator rehabilitation and violence prevention and is indeed simultaneously survivor-oriented, without the shame, guilt, and potential for harm that the false sense of security some perpetrator rehabilitation programmes may vicariously bring about for victims and perpetrators (Day, Chung and O'Leary, 2009).

The 'state' of attaining a sense of coherence also has to be located as a response to the gendered construction of aggressive forms of masculinity, often rooted in either cultural or other socially engineered ideas of what constitutes the ideal or desirable male role/s in society. Sense of coherence could be seen as a 'genderless' notion, one which is equally applicable to both men and women in its design. In its application within the salutogenesis framework, it has the potential to introduce a progressive understanding of gendered interactions, one that is non-violent and one that can serve as an ideal primary intervention methodology.

Conclusion

The recommendation, emanating from the Advice Desk's 25-year-history of crisis intervention, and recent scholarly reflection is to enhance the existing definition of health to include healthy interpersonal relationships by integrating the principles of Health Promotion (embedded in the Ottawa Charter) and The Universal Declaration of Human Rights (The United Nations, 1948) with Antonovsky's salutogenic concept.

In summary:

"Health promotion is the process of enabling individuals, groups or societies to increase control over, and to improve

their physical, mental, social and spiritual health. This could be reached by creating environments and societies characterised by clear structures and empowering environments where people are able to identify their internal and external resources, use and reuse them to realise aspirations, to satisfy needs, to perceive meaningfulness and to change or cope with the environment in a health promoting manner" (Eriksson and Lindström, 2007: 943).

Whereas rehabilitation programmes are *post-facto* interventions, employing salutogenesis as an approach has the potential to address risk factors such as a history of violent behavior, anti-social behaviours and attitudes, relationship instability, employment instability, mental health problems, an abusive childhood, low self-esteem and hostile attitudes toward women.

Civil society and state institutions have the opportunity to enhance the sense of coherence and learned resourcefulness (rather than learned helplessness) in a developmental rather than exclusively punitive mode. It is the conscious pursuit and relentless exploitation of these opportunities that is likely to relocate men who perpetrate abuse from the centre of the problem to the centre of the solution. The challenge before us is to translate everyday experiences to a sense of coherence and a sense of coherence to health and healthy interpersonal relationships. Traditional perpetrator programmes have started at the experience of the offence. Salutogenesis considers a wider range of experiences and contexts, preceeding and proceeding abuse and facilitates broader stakeholder engagement.

This approach however presumes that state and civil society initiatives are going to be working in a complementary fashion, to ensure that the environment of well-being and relative socio-economic equality is the status quo, to allow for a state of (sense of) coherence and a reciprocally better quality of life. However, in a country where an economic neoliberal paradigm is dominant, with high levels of poverty and unemployment (Bond, 2000; 2004), it would appear that the basic underlying assumptions required to implement a salutogenic model, are largely absent and only exist as an ideal. Therein lies an important area of interplay

between a citizen's "Sense of coherence" and their "Generalised resistance resources" (Antonovsky, 1996: 15). It is argued that the next logical stage is for a deeper engagement between State and civil society to emerge, which allows for an acknowledgement that post-incidence interventions are not a sustainable solution to addressing GBV. Preventative and early detection methodologies that extend constructs of public health by allowing for positive health choices rather than illness and punishment as their primary starting points, are more responsive and indeed more responsible and sustainable complementary approaches.

post-incidence interventions are not a sustainable solution to addressing GBV

Acknowledgements

The Advice Desk for the Abused is acknowledged for providing the practitioner platform upon which the above reflections were inspired. The above discourse is, in part, preparatory effort by Navindhra Naidoo toward a PhD in Forensic Pathology (University of Cape Town) to examine the broader role of health care providers in GBV. The authors acknowledge this effort toward a collaborative research project, funded by SANPAD, titled: 'Managing and responding to gender based-violence in South Africa through education, training and research: Synergies between practitioners and Higher Education Institutions – A case study of the Advice Desk for the Abused'. Lloyd Christopher and Stephen Harrison (both of Cape Peninsula University of Technology, Emergency Medical Sciences) are acknowledged for validating the above notions of intersectionality.

References

- Adams D A (1988) 'Counseling men who batter: A pro-feminist analysis of five treatment models', in M Bograd & K Yllo (eds) *Feminist Perspectives on Wife Abuse*, Newbury Park, CA: Sage.
- Altbeker A (2007) *A Country at War with Itself. South Africa's Crisis of Crime*, Cape Town: Jonathan Ball Publishers (Pty) Ltd.
- Alvesson M & Skoldberg K (2009) *Reflexive Methodology. New Vistas for Qualitative Research*. (2nd Edition) London: Sage, available at: <http://www.scribd.com/doc/53457775/28039-02-Alvesson-2e-Ch-02>, site accessed 8 October 2012.
- Antonovsky A (1996) 'The salutogenic model as a theory to guide health promotion', in *Health Promo Intl*, 11, 1, 11–18.
- Aschman G, Meer T & Artz L (2012) 'Behind the screens: Domestic violence and health care practices', in *Agenda*, 92, 26, 2, 51–64.
- Babcock J, Green C & Robie C (2004) 'Does batterers' treatment work? A meta-analytic review of domestic violence treatment', in *Clinical Psychology Review*, 1, 23, 1023–1053.
- Bond P (2000) *Elite Transition: From Apartheid to Neoliberalism in South Africa*, London: Pluto.
- Bond P (2004) *Talk Left Walk Right: South Africa's Frustrated Global Reforms*, Scottsville: Univerity KwaZulu-Natal Press.
- Bowen E, Brown L & Gilchrist E (2002) 'Evaluating probation based offender programmes for domestic violence perpetrators: A pro-feminist approach', in *The Howard Journal*, 41, 3, 221–236.
- Collins A (2009) 'Taking on Altbeker. A country at war with itself: The debate continues', in *SA Crime Quarterly*, 1, 28, 35–38.
- Day A, Chung D, O'Leary P & Carson E (2009) 'Programs for men who perpetrate domestic violence: An examination of the issues underlying the effectiveness of intervention programmes', in *J Fam Viol*, 24, 203–212.
- Eriksson M & Lindström B (2007) 'Antonovsky's sense of coherence scale and its relation with quality of life: a systematic review', in *British Medical Journal*, available at: <http://www.jech.bmj.com>, site accessed 26 June 2009.
- Feder L & Wilson D (2005) 'A meta-analytic review of court mandated batterer intervention programs: can courts affect abusers' behavior?', in *Journal of Experimental Criminology*, 1, 1, 239–262.
- Katzenellenbogen J, Joubert G & Abdoel-Karrim S (1999) *Epidemiology: A Manual for South Africa*, South Africa: Oxford University Press.
- Kovess-Masfety V, Murray M & Gureje O (2005) 'Evaluation of our understanding of positive mental health', in H Herman, S Saxena & R Moodie (eds) *Promoting Mental Health. Concepts, Emerging Evidence, Practice*, Geneva: World Health Organisation.
- Matthews S, Abrahams N, Martin L, Vetten L, van der Merwe L & Jewkes R (2004) "'Every six hours a woman is killed by an intimate partner': A national study of female homicide in South Africa", *MRC Policy Brief*, No 5.
- McCaul L (2005) 'The complexity of intersectionality', in *Journal of Women in Culture and Society*, 30, 3, 1771–1800.
- Mittelmark M (2008) 'Building healthy public policy the salutogenic way', The International Seminar on Salutogenesis Resources of Health and Quality of Life: Research, Policy and Practice and The

- 1st Meeting of the IUHPE Thematic Working Group on Salutogenesis, Helsinki.
- Moffett H (2001) *Entering the Labyrinth: Coming to Grips With Gender War Zones – The Case of South Africa*, United Nations International Research and Training Institute for the Advancement of Women, New York.
- Naidoo P (2010) "'The feminisation of poverty' as disabling discourse' in B Maharaj, A Desai & P Bond (eds) *Zuma's Own Goal: Losing South Africa's 'War on Poverty'*, Asmara: African World Press & Red Sea Press Inc.
- Norman R, Matzopoulos R, Groenewald P & Bradshaw D (2007) 'The high burden of injuries in South Africa', in *Bulletin of the World Health Organization*, 85, 9, 695–702.
- Norman R, Schneider M, Bradshaw D, Jewkes R, Abrahams N, Matzopoulos R *et al* (2010). 'Interpersonal violence: an important risk factor for disease and injury in South Africa', in *Population Health Metrics*, 8, 32, Queensland, Australia, available at: <http://www.pophealthmetrics.com/content/8/1/32>, site accessed 25 June 2011.
- Pence E & Paymar M (1993) *Education Groups for Men who Batter: The Duluth model*. New York: Springer-Verlag.
- Ramphela M (2012) SAFM Interview on AM Live, 8 October, (X. Gwala, Interviewer).
- Republic of South Africa (1998) The Domestic Violence Act, Act 116, *Government Gazette 19537*, Pretoria, South Africa.
- Sapa (2012) 'MRC says one woman a day killed in SA', Media 24, available at: <http://www.media24.com>, site accessed 7 November, 2012.
- Sonkin D J, Martin D & Walker L E A (1985) *The Male Batterer: A Treatment Approach*. New York: Springer-Verlag.
- Statistics South Africa (2011) *Statistics South Africa*, available at: <http://www.statssa.gov.za/publications/P0341/P03412011.pdf>, site accessed 8 October 2012.
- Stover C, Meadows A & Kaufman J (2009) 'Interventions for intimate partner violence: Review and implications for evidence-based practice', in *Professional Psychology: Research and Practice*, 40, 3, 223–233.
- Togari T, Sato M, Otemori R, Yonekura Y, Yokoyama Y, Kimura M *et al* (2011) 'Sense of coherence in mothers and children, family relationships and participation in decision-making at home: an analysis based on Japanese parent–child pair data', in *Health Promotion International*, 27, 2, 148–156.
- The United Nations (1948) The Universal Declaration of Human Rights. UN: New York, available at <http://www.un.org/en/documents/udhr/history.shtml>, site accessed 21 April 2013.
- van den Broucke S (2012) 'Editorial: Theory-informed Health Promotion: Seeing the bigger picture by looking at the details', in *Health Promotion International*, 27, 2, 143–147.
- Washington State Institute for Public Policy (2006) *Evidence-Based Adult Corrections Programs: What Works and What Does Not*, Washington State Institute for Public Policy: Washington.
- World Health Organisation (WHO) (1986) *Ottawa Charter for Health Promotion: an International Conference on Health Promotion, the Move Towards a New Public Health*, Geneva: World Health Organisation.
- World Health Organisation (2006) *WHO Multi-country Study on Women's Health and Domestic Violence Against Women*, Geneva: WHO.



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briefing



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