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Understanding Intimate Femicide in South Africa

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DEDICATION

In loving memory of my mother a giving, gentle person whose unconditional love and support taught me to believe in myself.

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To my colleagues at the Gender and Health Research Unit, Medical Research Council who guided me through the conceptualisation and implementation of this study, as well as for the stimulating academic discussions, constructive feedback and support that made this thesis possible.

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ABSTRACT

Title: Understanding intimate femicide in South Africa

When a woman is killed she is most likely to be murdered by an intimate partner. This form of homicide known as intimate femicide is conceptualised to be the most extreme consequence of intimate partner violence. Not much is known about such killings in South Africa or in other developing settings. This thesis studied intimate femicide using two complimentary studies from two methodological perspectives. The first study was quantitative with the aim of describing the incidence and pattern of intimate femicide in South Africa. The second study used qualitative methods and explored the social construction of the early formation of violent masculinities. Five papers written from these two studies are presented in this thesis.

Study one was a retrospective national mortuary-based study and collected data on all female homicides, 14 years and older, who died in 1999 from a stratified, multi-stage sample of 25 mortuaries. Data was collected from the mortuary file, autopsy report, and a police interview. The second study used a cluster of qualitative in-depth interviews with 20 incarcerated men in prison who have been convicted for the murder of an intimate partner, as well as interviews with family and friends of both the perpetrator and the victim.

Overall it was found that 50.3% of women murdered in South Africa are killed by an intimate partner, with an intimate femicide rate of 8.8/100 000 and an intimate-femicide suicide rate of 1.7/100 000 females 14 years and older. Blunt force injuries were shown to be associated with intimate killings, while gun ownership was associated with intimate femicide-suicides.

Elevated Blood Alcohol Concentration (BAC) combined with unemployed status was also found to be associated with intimate killings. The qualitative study showed that traumatic childhood experiences such as violent and neglectful parenting practises particularly by mothers made these men feel unloved, inferior and powerless with this found to be a pathway to violent models of masculinity used as a means to attain power and respect. This study shows that such traumatic experiences can lead to a suppression of emotions. It is argued that cognitive dissonance act as a protective mechanism which allows these men to perpetrate acts of violence without consideration of its impact.

These findings suggests that intimate femicide is a complex phenomenon with a “web” of associated and mediating factors which all contribute to it excessive levels in South Africa. It shows that intimate femicide is an extension of intimate partner violence and as such has to take into account the unequal gender relations in society. Building gender equity and shifting patterns of femininity and masculinity is a key strategy in reducing this form of violence.

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11. **Study Two: Informed Consent forms**

List of Publications

This thesis is based on the following papers which will be referred to in the text by their Roman numerals.

I. Abrahams, N., Martin, L. J., Mathews, S., Vetten, L., & Lombard, C. 2009, "Mortality of women from intimate partner violence in South Africa: A National Epidemiological Study", *Violence and Victims*, vol. 24, no. 4, pp. 546-556.

II. Mathews S, Abrahams N, Jewkes R, Martin LJ, Lombard C & Vetten L**.**2009**:** Injury Patterns of Female Homicide in South Africa: Findings from a National Study , *Journal of Trauma*. 67(1).pp168-172.

III. Mathews S, Abrahams N, Jewkes R, Martin LJ, Lombard C.2009: Alcohol use and its role in female homicides in the Western Cape, South Africa. *Journal of Studies on Alcohol and Drugs*. 70(3). pp321-327.

IV. Mathews S, Abrahams N, Jewkes R, Martin LJ, Lombard C & Vetten L.2008. Intimate Femicide-Suicide in South Africa, *WHO Bulletin*. 86(7).552-558.

V. Mathews S, Jewkes R, Abrahams N. “I had a hard life”: Exploring childhood adversity in the shaping of masculinities among men who killed an intimate partner in South Africa. Submitted Social Science and Medicine. March 2010.

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CHAPTER ONE

INTRODUCTION AND LITERATURE REVIEW

1.1 Overview

South Africa is an extraordinary violent country with homicide levels five times higher than the global average (Seedat et al. 2009). The overall age standardised homicide rate for 2000 is 64.8 per 100 000, confirming that the country is amongst the most violent in the world (Norman et al. 2007). In addition, burden of disease studies indicate that homicide and interpersonal violence together are leading causes of injury deaths while violence and unintentional injuries combined are the second leading cause of healthy years of life lost (YLL's), after HIV/AIDS (Norman et al. 2007;Seedat et al. 2009). Homicide, therefore, poses a substantial public health burden due to premature mortality and is considered to be preventable.

A distinct feature of violence in South Africa is its gendered nature, with males disproportionately affected both as perpetrators as well as victims of violence (Krug et al. 2002; Seedat et al. 2009). The difference in gender dynamics of homicide is highlighted by the age pattern as homicide victimisation rates for men peak in the 15- 29 age group, while for women the peak is in the older age group, 30-44 year (Norman et al. 2007). It has been argued that male violence is rooted in dominant constructions of masculinity which glamorise toughness and strength with an eagerness to take risks and engage in physical retaliation (Morrell 1998; Seedat et al. 2009). A man is therefore most likely killed by an acquaintance than a stranger and such killings frequently occur in a public space linked to recreational activities and in the context of interpersonal conflicts (Seedat et al. 2009).

Conversely, when women are murdered, they are more likely killed in their homes than men (Matzopoulos 2005).

Internationally, it was found that when a woman is killed, she is most likely killed by an intimate partner (Adinkrah 1999; Kellermann & Mercy 1992; Mercy & Saltzman 1989). The World Report on Violence and Health reports that between 40-70% of all female homicides are perpetrated by an intimate partner (Heise & García-Moreno 2002). This form of homicide is known as intimate femicide or intimate partner femicide and conceptualised as the most extreme form and consequence of intimate partner violence.

Even though intimate partner violence is widespread not much is known about such killings in South Africa. There are no reliable national population based estimates for intimate partner violence in South Africa, but a population based prevalence study conducted in three provinces estimated that one in four women has a lifetime experience of intimate partner violence (Jewkes, Levin, & Penn-Kekana 2002). This is considered an underestimation, as various sub-sample studies have revealed much higher prevalence figures of between 40-50% (Abrahams et al. 2006; Dunkle et al. 2004; Dunkle et al. 2006; Jewkes et al. 2006). Intimate partner violence is thus considered normative in South African society due to notions of a gender hierarchy and a general tolerance of violence within intimate relationships (Jewkes 2002; Seedat et al. 2009). Theoretically intimate partner violence is a product of social context with social norms legitimising men's use of power over women (Jewkes 2002; Wood, Lambert, & Jewkes 2008). Men's use of violence in intimate relationships therefore establishes their dominance over women, maintaining a patriarchal gender order (Jewkes 2002).

1.1.1. Violence against women as a human rights issue

The recognition of intimate partner violence as a health and human rights issue is recent and located within the discourse on violence against women. The demise of Apartheid has resulted in major policy shifts within South Africa. Gender equality and advancing the rights of women became a key policy commitment of the ANC led government. The South African constitution which was adopted in 1996 provided women with a full range of rights including the right to be free from violence (Republic of South Africa 1996). The State thus introduced a range of measures like, setting up of the national gender machinery through establishing an Office on the Status of Women; the Commission on Gender Equality; an ad-hoc Committee on the Quality of Life and Status of Women; revamping legislation and policies such as introducing Employment Equity legislation; Domestic Violence Act No 116 of 1998 (Republic of South Africa 1998), new legislation for sexual offences; as well as ratifying international treaties such as The Convention on the Elimination of all forms of Discrimination against Women (United Nations 1992); UN Declaration on Violence against Women (1993); UN Human Rights Summit (Vienna, 1993); International Conference on Population and Development (Cairo, 1994); Fourth World Conference on Women (1995) which all solidified their intent to work towards the eradication of violence against women.

The Domestic Violence Act No 116 of 1998 (Republic of South Africa 1998) was the first legislative step of the democratic government to address intimate partner violence as a human rights issue in South Africa. The Act broadened the scope of domestic violence significantly when it expanded the definition to include a range of experiences, namely physical, sexual, emotional, verbal and psychological abuse. The revised Act also made

provision for acts of intimidation, harassment and stalking. The legislation was heralded by many women's organisations as "progressive" in how it set out to protect women. The preamble to the Act clearly articulated the State's intention to address domestic violence by "providing victims with the maximum protection the law can provide". Policy is, however, only the first step in the process of developing an appropriate response to reduce levels of intimate partner violence, as it requires political will and an understanding of the complexities of intimate partner violence (Dangor, Holt, & Scott 1998).

Research on the implementation of the Domestic Violence Act No 116 of 1998 (Republic of South Africa 1998) has shown that a law reform process does not translate into changing women's experiences of violence as the availability of, and easier access to, legal remedies does not free women from violent experiences in their homes (Mathews & Abrahams 2001; Parenzee, Artz, & Moult 2001). Although the Act enables women to access protection orders more easily, it does not address the male partner's violence. The Act makes no provision for men's programmes to reduce violence and therefore the emphasis is solely on women. However, to effectively reduce levels of intimate partner violence one requires strategies that address both men and women as it is a problem affecting both genders.

In his first State of the Nation address our Honourable President, Jacob Zuma made mention of both and said:

"*The most serious attention will also be given to combating organised crime, as well as crimes against women and children*" (*The Presidency June 3, 2009).*

The President hereby recommitted the State to addressing violence against women and children, but again framed it within the criminal justice discourse of crime and crime prevention. Social norms and gender relationships contribute to the dominant notions of what it means to be a man, with behaviours such as multiple sexual partners, male sexual entitlement, use of violence viewed as a legitimate means to discipline a female partner, all contributing to the subordination of women (Connell 1987; Coovadia et al. 2009). Criminal sanctions to address violent male behaviour are not enough. It is imperative to change violent male practises by developing an understanding of pathways to the construction of violent masculinities.

1.1.2. Organisation of Thesis

The focus of this thesis is intimate femicide, conceptualised as an extension of intimate partner violence. Little is known about the antecedents of such murders in South Africa. Furthermore this phenomenon has mainly been explored in developed settings with no systematic investigation into its occurrence in developing countries. Developing an understanding of the factors which increase women's risk of being a victim of intimate partner femicide is critical in the development of prevention strategies to reduce the occurrence of such killings. This thesis will therefore be addressing the gaps in knowledge on this phenomenon by describing the multifaceted dimensions of intimate femicide.

This thesis will present a group of papers as a collective to further our understanding of this phenomenon. These papers approach the subject from a broad public health perspective and use both quantitative and qualitative methods to develop an in-depth understanding of

intimate femicide within the South African context. This thesis contributes to our epidemiological understanding of intimate femicide, as well as deepens our understanding of men as perpetrators through a qualitative exploration of men as perpetrators of intimate femicide. The issues addressed by each paper are different yet connected to form a collective body of knowledge on intimate femicide.

Paper I is a supplementary co-authored paper which provides the overview of female homicide and provides the background on intimate femicide in South Africa (Abrahams et al. 2009). Paper II addresses injury patterns of female homicide victims as an important aspect of the medico-legal investigation. Understanding injury patterns is of significance in South Africa, as the country has a relatively low murder conviction rate due to flaws in the criminal investigation (Legget 2003). An understanding of injury patterns can alert both the pathologist and police to the possible perpetrator thereby assisting in the pursuit of justice. Paper III explores the role of alcohol in female homicides which is a neglected, but critical area in public health. The link between high alcohol consumption and perpetration is well established (WHO 2005). However, our understanding of the linkages between female alcohol use and intimate partner violence is limited. A study with working men in South Africa on their use of violence in intimate relationships found that female alcohol use is used as justification for male violence (Abrahams et al. 2006). Paper IV focuses on intimate femicide-suicide and provides with novel insights into the important problem of the intersection between intimate femicide and suicide of the perpetrator. This is of significance for public health as it explores the factors associated with such killings and provides us with information that may contribute to prevent such double deaths. Paper V in this thesis draws on a qualitative enquiry into the social construction of masculinities of men who have killed

an intimate partner. This paper explores how childhood experiences influence the formation of masculine identity. This is a critical area for prevention as little is known about the early formation of violent masculinities in the South African context.

This thesis addresses gaps in our knowledge on intimate partner femicide within the South African context through an exploration of the factors which increase the risk for such killings. Through the systematic exploration of this phenomenon it is envisaged that it can be helpful for prevention as well as intervention strategies, by first identifying women who may be at risk of being a victim of such murders, secondly informing female homicide investigations through the provision of knowledge on injury patterns. It will also inform strategies to prevent men from adopting violent constructions of masculinities.

1.2 Background

Historically, intimate partner violence has been marginalised as a women's issue and considered to be a private matter. Although it is one of the most common forms of violence against women globally, with serious health and development consequences, only recently has it been recognised as an important public health and human rights issue (Ellsberg 2006; Heise & García-Moreno 2002). Following concerted advocacy efforts from the women's movement globally violence against women was condemned, at the 11th session of The Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) in 1992. Subsequent United Nations conferences articulated international policy commitments to eradicate violence against women through the signing of agreements (Ellsberg 2006).

1.2.1. Public health significance of intimate partner violence

The World Health Report on Violence and Health defines intimate partner violence as any act by an intimate partner that causes physical, psychological or sexual harm and includes various forms of controlling behaviour (Heise & García-Moreno 2002). Although this form of violence is widespread and well documented, comparing data across countries and regions are difficult (Ellsberg 2006; Heise & García-Moreno 2002; Jewkes 2000). Many women are reluctant to disclose their experiences of intimate partner violence due to feelings of shame, fear of blame or disloyalty to their partners due to cultural practices and norms within communities (Jewkes 2000). The reliability of prevalence estimates is further affected by the way violence is defined, selection criteria for study participants and data sources (Ellsberg et al. 2001). The World Health Organisation (WHO) therefore developed ethical and safety recommendations for research into domestic violence against women to enhance the

methodological quality of studies as well as to improve disclosure and ensure the safety of respondents and interviewers (WHO 1999). To address the need to make data comparable and to provide reliable prevalence estimates across countries, the WHO study on Women's Health and Domestic Violence was conducted in 10 countries and across 15 diverse sites: Bangladesh (city and rural province), Brazil (city & rural province), Ethiopia (rural province only), Japan (city), Namibia (city), Peru (city and rural district), Samoa (whole country), Serbia & Montenegro (city), Thailand (city and rural province) and Tanzania (city and rural province) (García-Moreno et al. 2006).

The WHO multi-country study found that the reported lifetime prevalence of intimate partner violence for physical and sexual violence combined ranged between 15% (Japan city) and 71% (Ethiopia province), with most sites reporting estimates of between 29% and 62% (García-Moreno et al. 2006). Japan consistently reported the lowest prevalence for all forms of violence while developing countries such as Bangladesh, Ethiopia, Peru and Tanzania reported the highest prevalence figures (García-Moreno et al. 2006). Considerably lower estimates were found for violence experienced in the previous 12 months with sites such as Japan, Serbia and Montenegro and Brazil (city) all reporting less than 10% prevalence in the past year (García-Moreno et al. 2006). Prevalence studies from other developed countries support this pattern. A national telephonic survey on violence against women in Australia reported a 34% lifetime experience of intimate partner violence, with less than 5% prevalence for the past year (Mouzos & Makkai 2004). Using similar methods, a national population based study in 11 cities in the United States established a prevalence of 9.8%, of physical and or sexual violence or threats of such in the past two years by a current or former partner (Walton-Moss et al 2005).

Apart from the WHO study, few prevalence studies have been conducted in less developed countries with the only source of data for most coming from Demographic Health Survey's (DHS). A comparative study using DHS data from nine developing countries namely; Cambodia, Colombia, the Dominican Republic, Egypt, Haiti, India, Nicaragua, Peru and Zambia (Kishor & Johnson 2004). The highest reported prevalence for lifetime experience was in Zambia (48%) followed by Columbia (44%) then Peru (42%). The lowest figures were reported for Cambodia (17.5%), India (18.9%) and the Dominican Republic (22.3%), with Egypt (34.4%), Haiti (35.5%) and Nicaragua(32.6%) reporting similar prevalence figures (Kishor & Johnson 2004). Data on experience in the past year was not available for all sites but where available, confirmed lower levels with Zambia remaining the highest (26.8%) with lowest figures reported for India (10.3), the Dominican Republic (11%) and Egypt (12.5%) (Kishor & Johnson 2004). These prevalence figures for countries such as India and Cambodia are particularly low, and once again it cautions us against adding questions of intimate partner violence to studies undertaken for other purposes. Studies in South Africa and Nicaragua have found that prevalence from DHS studies substantial underestimates when compared with dedicated violence against women surveys (Ellsberg et al. 2001; Jewkes et al. 2000b). Nevertheless, these studies all confirm the widespread problem of intimate partner violence.

In South Africa there are no reliable national prevalence estimates for intimate partner violence. A dedicated population based violence against women survey in three South African provinces reported prevalence estimates for lifetime experience of physical violence ranging from 19.1% (Northern Province), 26.8% (Eastern Cape) to 28.4% (Mpumalanga)

(Jewkes et al. 2000a). Much lower estimates were also reported for experiences of violence in the past year ranging from 4.5% (Northern Province), 10.9 % (Eastern Cape) to 11.9% (Mpumalanga)(Jewkes et al. 2000a). Studies conducted within varied sub-populations suggest that these reported estimates probably underestimate the true scale of the problem. A case control study comparing pregnant and non-pregnant adolescents in Cape Town reported 59% had experienced physical intimate partner violence in an intimate relationship with no difference between the two study arms (Jewkes et al. 2001). In a cross-sectional survey of antenatal attendees at Chris Hani Baragwanath Hospital, 55.5% reported a lifetime experiences of physical and sexual violence by an intimate partner and 30.1% reported experience in the past year (Dunkle et al. 2004). In a volunteer sample of adolescents recruited into a randomised control trial of an HIV behavioural intervention with adolescents aged 15–26 years, 26.6% of the females reported experiences of more than one episode of physical or sexual violence (Jewkes et al. 2006).

Studies with men have confirmed these high rates of intimate partner violence. The best current evidence is from a randomised, population based survey of men in the Eastern Cape and KwaZulu Natal Provinces, 42.4% of men reported ever using physical violence in an intimate relationship, with 14.0% reporting it in the past year (Jewkes et al. 2009). An earlier cross-sectional survey of working men in Cape Town reported similar levels of violence, 42.3% reported physical violence against an intimate partner within the last 10 years, with 8.8% doing so in the last year, with much lower rates of reported sexual violence of 8.8% in the last 10 years (Abrahams et al. 2006). In addition, in a volunteer sample of a randomised control trial with adolescents in the rural Eastern Cape 31.8% of young men reported physical or sexual violence against and intimate partner (Dunkle et al. 2004). In a recent

analysis using data from men who participated in the South African Stress and Health Study, 27.5% reported using physical violence in the most recent intimate relationship which is the lowest prevalence figure based on survey data with men (Gupta et al. 2008). This emphasises the caution which is needed when adding questions on intimate partner violence to surveys designed for other purposes (Campbell, Abrahams, & Martin 2008).

Studies on intimate partner violence have shown that acts of violence rarely occur on their own but coexist with other forms of violence (Heise & García-Moreno 2002). The WHO multi-country study confirms this overlap with between 30% and 56% of women who reported experiences of intimate partner violence also described partner sexual violence (García-Moreno et al. 2006). This study does not report on the overlap between these all forms of violence but on experiences of emotional acts as a separate category, with women in the Ethiopian province reporting the highest levels of emotional abuse, 75% in their lifetime and 57.5% in the past year (García-Moreno et al. 2006). Other studies have reported a substantial overlaps, in particular with psychological violence, in countries such as Nicaragua, United States and Spain (Ellsberg et al. 1999; Ruiz-Pérez et al. 2006; Thompson et al. 2006). Similarly in a South African study at antenatal clinics in Soweto women reported multiple overlaps of violence; 29.8% reported partner psychological as well physical violence, 13.4% reported psychological and sexual, while 84.8% of women who reported both partner physical and sexual violence also reported partner psychological abuse (Dunkle et al. 2004).

1.2.2 Theories on Intimate Partner Violence

The factors underlying the widespread problem of intimate partner violence are complex. In the past, conceptualisation of this problem was approached at an individual level, construed as a private issue, which was culture specific. Early theories focussed on the individual as victim or perpetrator proposing single factor explanations (Heise 1998). Even though these theories are extensive and beyond the scope of this thesis, the leading theories will nevertheless be highlighted. Feminist approaches largely hypothesised that violent male behaviour is rooted in the patriarchal nature of most societies, with men's power over women a key driver behind intimate partner violence (Dobash & Dobash 1979, Dobash & Dobash 2003). They continue to argue that this form of violence should be conceptualised as social constructions based on the status of women within families which permits men to have control over women (Dobash & Dobash 1979, Dobash & Dobash 2003). Social learning theory posits that behaviour is learned through modelling what is experienced within the environment (Bandura 1977); in particular, both witnessing a mother being abused as well experience of abuse in childhood are both important risk factors for perpetration of violence against an intimate partner. Furthermore, systems theory proposes that intimate partner violence should be viewed within the context of family violence, with violence a product of patterns of family interaction rather than individual pathology (Gelles & Straus 1979).

From a public health perspective, Heise (1998) proposed an integrated ecological framework. Within this model intimate partner violence is viewed as a multifaceted phenomenon which intersects with personal, situational and socio-cultural levels of causality. This framework utilises empirically proven risk factors at the individual, relationship, community and societal level (Heise 1998; Heise & Garcia Moreno 2002).

Factors included at the individual or personal level are: having been abused as a child; witnessing marital violence in the home, which have also been highlighted by Bandura(1977) and Gelles & Straus (1979); as well as an absent or rejecting father; alcohol abuse; and a personality disorder (Heise & García-Moreno 2002; Heise 1998). At the relationship or family level there are factors such as marital conflict; male dominance in the family; and male control over family money (Heise & García-Moreno 2002; Heise 1998). These factors are also highlighted in the feminist approaches (Dobash & Dobash 1979). Factors identified at community level are women's isolation and lack of social support; community attitudes to intimate partner violence; low socio-economic status or unemployment (Heise & García-Moreno 2002; Heise 1998). Lastly, at societal level male entitlement related to notions of ownership of women; rigid gender roles; masculinity linked to male dominance; cultural norms associated with a tolerance of intimate partner violence (Heise & García-Moreno 2002; Heise 1998). These factors were also highlighted by the feminist approaches (Dobash & Dobash 1979).

Jewkes and colleagues (2002) however argue that not all factors presented within the ecological framework are supported by research from other settings, such as risk factor studies from South Africa, and suggests that the model has inherent conceptual flaws. Jewkes and colleagues (2002) maintain that factors are often interrelated and cannot be isolated and pigeon holed into a particular level, as they are cross-dimensional. Jewkes (2002) proposes a web of associated and mediating factors which at its core has the position of women and notions of masculinity and the culture of violence in society which impact on the prevalent ideas of violence and how violence then plays out in intimate relationships.

1.2.3 Social Dynamics of Intimate Partner Violence

Understanding the dynamics of intimate partner violence is complicated. From a public health perspective Jewkes (2002) argues that intimate partner violence is entirely based on social context rather than biologically instinctive male factors. Cross cultural ethnographic studies have shown that intimate partner violence is not prevalent in all societies (Counts, Brown, & Campbell 1992; Levinson 1989). Moore (1994), from an anthropological perspective, proposes that the social positioning of women in relation to men supports men's use of violence as a means to control women. Ethnographic work with young men in the Eastern Cape has shown that violence in intimate partnerships is used as a means of discipline and control, used to maintain a patriarchal gender order and associated with a desirable masculinity (Wood, Lambert, & Jewkes 2008). Importantly, studies have also shown that some women perceive intimate partner violence to be justified based on what is perceived as a "just cause" which is rooted in notions of cultural gendered roles, which female legitimise men's use of violence (Heise & García-Moreno 2002; Uthman, Lawoko, & Moradi 2009; Wood, Lambert, & Jewkes 2008) (Koenig et al. 2003; Lawoko 2006; Pelser et al. 2005). It is argued that it is socially accepted as long as the violence is not too severe or visible to others (Wood, Lambert, & Jewkes 2008). Violence in intimate relationships is also tolerated in societies where it is considered a private matter and trivialised by police, with women expected to remain in a marriage at all costs (Jewkes 2002). In societies where violence is normalised through war or crime, violence is used as a strategy to resolve disputes (Abrahams et al. 2006; Jewkes 2002, Counts et al 1992).

1.2.4 Risk factors associated with intimate partner violence

Our understanding of the factors associated with intimate partner violence has been extended due to a number of well designed studies using both quantitative and qualitative designs, with a focus on both men and women (Jewkes, Levin, & Penn-Kekana 2002). However, establishing causation in terms of epidemiological criteria is difficult as the aetiology of intimate partner violence is social (Jewkes 2002). Nevertheless, factors which have been found to be associated with intimate partner violence are explicated in the section below:

i. Socio-demographic Factors:

Age has been found to be associated with intimate partner violence in some settings with a greater risk to younger women (Moracco et al. 2007; Ruiz-Pérez et al. 2006), while other studies found no association (Ellsberg et al. 1999; Jewkes, Levin, & Penn-Kekana 2002; Martin et al. 1999; Walton-Moss et al. 2005). A secondary school education or higher in women has been shown to reduce the risk of partner violence, suggesting that when women are more empowered they are in a better position to protect themselves (Jewkes, Levin, & Penn-Kekana 2002; Karamagi et al. 2006; Koenig et al. 2003; McCloskey, Williams, & Larsen 2005). Leaving school early and having no further education was found to be associated with an increase in risk for perpetration of intimate partner violence (Abrahams et al. 2006; Hoffman, Demo, & Edwards 1994; Martin et al. 1999).

ii. Childhood Experiences

Experiences of witnessing a mother's abuse and being beaten in childhood have also been shown to be associated with an increase in risk of being both a victim and perpetrator of

intimate partner violence (Abrahams et al. 2006; Jewkes, Levin, & Penn-Kekana 2002; Koening et al. 2006). This relationship is complex as such childhood experiences might normalise the use of violence, while they might also impact on self-esteem with a difference in effect for men and women. Early sexual debut, before 15 years of age, was also found to be associated with an increase in risk of partner violence (Koenig et al. 2003). This association might be confounded by the fact that early sexual debut is often coercive and therefore such women have an increased vulnerability in future relationships. Forced first sex was found to be significantly associated with intimate partner violence in a hospital based study in South Africa (Dunkle et al. 2004).

iii. Alcohol and violence

Alcohol use by men has consistently been found to be associated with an increase risk of intimate partner violence in diverse settings (Abrahams et al. 2006; Heise & García-Moreno 2002; Hoffman, Demo, & Edwards 1994; Jewkes, Levin, & Penn-Kekana 2002; Martin et al. 1999). Jewkes and colleagues (2002)argues that it is not necessarily his drinking but the ensuing conflict associated with his drinking which results in violence. Alcohol thus has a disinhibiting effect which can fuel violent conflicts. There is also some evidence to suggest that at times men drink to give them the courage to be violent towards an intimate partner, when this is what is socially expected (Abrahams et al. 2006). A study with men in South Africa found that men who were violent were more likely to use drugs currently (Abrahams et al. 2006), it has been argued that drugs reduce inhibition, having a similar effect to alcohol (Jewkes 2002). Women's alcohol consumption has been found to be associated with an increased risk of victimisation (Jewkes, Levin, & Penn-Kekana 2002), with men also using this as justification for using violence (Abrahams et al. 2006).

Involvement in fights at work and in the community has been found to be associated with perpetration of intimate partner violence (Abrahams et al. 2006). This suggests that a general "culture of violence", a tolerance for violence, influences how conflicts are resolved within intimate relationships.

iv. Gender and power in relationships

Ideas on male superiority which is defined by conservative ideas on the role of women, notions of male sexual entitlement as well as men's risky sexual practices are all associated with intimate partner violence (Jewkes, Levin, & Penn-Kekana 2002). A study in Tanzania and North India found an association between having problems to conceive with an increased risk of intimate partner violence (Koening et al. 2006; McCloskey, Williams, & Larsen 2005). In addition, a South African population based survey found an association between the male partner's preference for a boy child and intimate partner violence (Jewkes, Levin, & Penn-Kekana 2002). Shifts in a women's role is proposed to create a "crisis" of male identity increasing the risk for use of violence (Jewkes, Levin, & Penn-Kekana 2002). Findings from this study also that found that by having more liberal ideas about her relationship, as well as the female having more than one partner concurrently in the past year, increase a women's risk of experiencing intimate partner violence (Jewkes, Levin, & Penn-Kekana 2002). In addition, men's risky sexual practises related to ideas of male superiority also increase the risk for intimate partner violence. This is supported by findings from a randomised controlled trial in South Africa that found men who reported more lifetime and past year partners, transactional sex, substance abuse, non-partner rape were more likely to report violent behaviour towards an intimate partner (Dunkle et al. 2004). An

association between intimate partner violence, risky sexual behaviour and HIV was also established in a randomised population-based survey with men in the Eastern Cape and KwaZulu-Natal Provinces (Jewkes et al. 2009), confirming this association. Furthermore, community attitudes towards intimate partner violence as well as overall high levels of violence were found to be associated with intimate partner violence in North India (Koening et al. 2006). Therefore, the gendered position of women in society combined with dominant constructions of masculinity and femininity all contribute to the general tolerance of intimate partner violence.

Conflict within the relationship has emerged as a consistent factor associated with intimate partner violence in South Africa (Abrahams et al. 2006; Jewkes, Levin, & Penn-Kekana 2002). Violence is often used as a tactic when there is conflict in the relationship (Jewkes 2002), with men more likely to respond violently when there is conflict over his infidelity (Abrahams et al. 2006). Conflict over sex also heightens the risk of violence in the relationship (Abrahams et al. 2006), which is linked to sexual entitlement and has been identified in qualitative research as a central feature of being a "successful" South African man (Wood & Jewkes 2001). Controlling male behaviour was also found to be associated with intimate partner violence and an increased risk of HIV (Dunkle et al. 2004); this connection appears to also be rooted in the entrenched gender hierarchy in South Africa, legitimising men's control over women.

v. Masculinities

Men are overwhelmingly shown to be the main perpetrators of violence. Men's use of violence has conceptually been addressed from a range of perspectives and has received

much attention over the past two decades. Understanding men's use of violence is linked to notions of masculinity and is thus an integral part of this discussion. Masculinities are construed as a configuration of practices shaped by gender relations between men and women and influenced by factors such as gender division of labour, power distribution, as well as emotional relations (Connell 1987). She further proposes that masculinities and femininities are constructed as a consequence of a patriarchal gender order, which centers around male dominance over women (Connell 1987). The discourse on masculinities has significantly been influenced by the concept of "hegemonic masculinity" introduced by Connell (1987).

Hegemonic masculinity is conceptualized as the dominant form of masculinity in a society, in contrast to other less dominant forms of masculinities, complicit, subordinated and marginalized masculinities (Connell 1995). Importantly, hegemonic masculinity is not based on force or total cultural dominance, it is viewed as the most respected and idealized form of masculinity, a cultural "ideal", such as epitomized by an idealized sports star. This is a masculinity which may not be achievable for most men (Connell 1987). Nonetheless the majority of men benefit from the domination of women through the institutionalization of patriarchal practices at all levels of society (Connell 1987) and aspire to such aspects of the model as are attainable. Hegemonic masculinity is thus viewed as the exalted form of masculinity and in many respects an ideal, although it is not violent *per se,* to maintain dominance violent strategies can be and often are used (Connell 1995).

Recently there has been debate around rethinking the use of the term "hegemonic" masculinity. Criticism has been leveled at how Connell(1987) used the notion of gender

relations, with it conceptualised as a “singular pattern” of gender hierarchy, not taking into account the intricate interplay of different forms of masculinities or the agency of women, and too rigid in how its views gender relations (Beasley 2008; Connell & Messerschmidt 2005). Furthermore, Beasley (2008) argues that there are internal contradictions in the use of the term as the dominant form of masculinity, as it does not always mean that this form of masculinity holds legitimate power, neither is it always the most socially respected. Although this term has its limitations, debating the use of the term is important in furthering our understanding of masculinities and femininities. It is thus an important tool to explore dominant constructions of masculinities and femininities by taking onto account the differences between men but simultaneously exploring the unifying factors that provide men with dominance over women.

Nevertheless, the focus in South Africa on masculinities, although drawing on the work of masculinity scholars from developed countries has been more focused on how these ideas are translated into practice; taking into account the influence of history, context and culture in the construction of diverse masculinities (Gibson & Hardon 2005; Morrell 2001; Ouzgane & Morrell 2005). Masculinity, or male gendered identity, is thus conceptualised as socially constructed and ever changing with culture, the family, school, church, class all influencing the formation of masculinities (Morrell 2001).

South Africa’s colonial past, as well as apartheid, with experiences of war and violence, shaped our racially-based masculinities (Coovadia et al. 2009; Morrell 1998). For White men the exposure to war through national conscription into the army has resulted in dominant constructions of masculinities based on toughness, physical strength, courage and respect

for a hierarchy of authority (Coovadia et al. 2009; Morrell 1998). For African men apartheid significantly influenced the reshaping of African masculinities as traditional aspects of manhood became unattainable (Coovadia et al. 2009). Urbanisation and migrant labour affected not only family life and views on women, but also changed traditional ways of socialization which influenced how interpersonal conflict is resolved with a willingness to use violence and weapons now common (Coovadia et al. 2009; Morrell 1998). Furthermore, the armed struggle produced a generation of men who are familiar with the use of violence to deal with conflict (Xaba 2001). It is thus argued that apartheid produced a militarized society particularly for men, with gun ownership and gun violence linked to dominant models of masculinity (Cock 2001). Another feature of South African masculinities is gang involvement for some African and Coloured young men. Gangs in many respects are oppositional to both the state and traditional ways of life. Gang masculinity is marked by criminal activities and the ready use of violence and weapons, in particular guns. It has been proposed that disempowerment and being unable to attain manhood through traditional ways resulted in taking on a hyper-masculine identity as an alternative (Luyt & Foster 2001), which valorises risk-taking, toughness and violence, with sexual entitlement exaggerated within gang culture (Coovadia et al. 2009; Wood & Jewkes 2001). Importantly, recent ethnographic research with young men in South Africa proposes that female obedience and control of women are key elements in current constructions of masculinity and that violence is used as a strategy to secure respect and control (Wood & Jewkes 2001; Wood, Lambert, & Jewkes 2008). The dominant notion of what it means to be a "successful" man is therefore based on a distinct gender hierarchy and characterized by behaviours such as having multiple sexual partners; substance abuse; ready use of violence

to resolve conflict; with these risk taking practices driving our two major public health problems; violence and HIV (Coovadia et al. 2009; Seedat et al. 2009).

Jewkes et al (2002) suggests that to understand why only certain men are violent towards intimates one has to reflect on male identity. Based on the work of Moore (1994) it is conceptualised that when a man perceives his power to be under threat, perceptions such as of the infidelity of a female partner, creates a crisis of identity. This threat to his male identity is linked to both his sense of losing power in his intimate relationship as well as his perception that his partner's infidelity will reflect on his inability to control her and this will influence his social evaluation by others (Moore 1994). It is this threat, whether real or fantasy, that results in acts of intimate partner violence, with this form of violence used as a means to regain a sense of power and control in the intimate relationship. It has also been

argued that adopting violent forms of masculinities is a means to gain power and status in the quest to attain a successful masculinity in settings where men are structurally disempowered (Bourgois 1996). Wood and Jewkes (2001) argue that this cannot fully explain violence against intimate partner as this not a necessary part of a "successful" masculinity, nevertheless violence in an intimate relationship is accepted in the context of discipline and in the defense of honour. Therefore the use of violence can be viewed as a part of a struggle to maintain respect through discipline and control of female partners (Wood & Jewkes 2001; Wood, Lambert, & Jewkes 2008). The prevailing social norms provide an environment where men's violence towards women is tolerated within certain boundaries (Jewkes 2002; Wood & Jewkes 2001, Campbell 1985).

vi. Poverty

Studies in different settings have found an association between poverty and intimate partner violence (Ellsberg et al. 1999; Koening et al. 2006; Martin et al. 1999). However, this association has not been consistent in developing settings. In Tanzania, a study has shown an increase in risk for partner violence when the man did not contribute financially to the household (McCloskey, Williams, & Larsen 2005). In contrast, a study from South Africa found that women who were poor and supported by a third party were protected from intimate partner violence, suggesting that support systems offer women some form of protection (Jewkes, Levin, & Penn-Kekana 2002). Furthermore, in a randomised control trial evaluating an intervention with microfinance, gender training and community action led to a reduction in levels of intimate partner violence in the community of women who were exposed to the intervention (Pronyk et al. 2006). This would suggest that it is not just the financial independence but also the support gained from being part of a group and the related empowerment which could be protective in partner violence.

1.2.5. Contextualising Female Homicide

Homicide and interpersonal violence combined is the second leading cause of injury deaths for women, following road traffic injuries. South Africa has an estimated age standardised female homicide rate of 21 per 100 000 (Norman et al. 2007). The Global Burden of Disease project estimates that the global rate for female homicide is 4.0 per 100 000 (Krug et al. 2002). Although there is a distinct difference in homicide rates for males and females in South Africa, with 5.4:1 male to female deaths (Norman et al. 2007), our female homicide rate is five times the global rate. The high levels of intimate partner violence prevalent in South Africa combined with excessive levels of female homicide raise concerns regarding the levels and patterns of intimate partner femicide.

1.2.6. Defining Femicide

"Femicide" as a term was first used by Diana Russell at the International Tribunal on Crimes Against Women in Brussels in 1976 (Russell & Harmes 2001). Russell and Radford (1992) only defined the term much later as "the misogynistic killing of women by men". This definition was extended to the "killing of females by males because they are females" nearly a decade later (Russell & Harmes 2001). This was an attempt to recognise that such crimes are based on the power and control men have over women of all ages, thus politicising the term. Internationally there has been debate around the use of the term and its definition (Widyono 2009). However there has been a growing body of research in the area of intimate partner femicide, which is in thesis defined as the most extreme consequence of intimate partner violence. It is this form of femicide which will be explored in this thesis.

1.2.7. Theories on intimate femicide

Conceptually intimate femicide is located within the scope of intimate partner violence as studies on intimate femicide have shown that the majority of such murders are preceded by intimate partner violence and should thus be considered a consequence of intimate partner violence (Bailey et al. 1997; Campbell 1992; Campbell et al. 2003; McFarlane et al. 2002; Mercy & Saltzman 1989; Moracco, Runyan, & Butts 1998). Theories on intimate femicide are an extension of those of intimate partner violence, and it is argued that such murders occur within the broader framework of patriarchal gendered relations (Radford & Russell 1992). Developing a conceptual understanding of why only some acts of intimate partner violence progress to killing is important and it is this distinction that needs to be understood by such theories. From a different perspective based on an evolutionary psychology framework

Canadian criminologists (Wilson & Daly 1992) developed a theory based on male sexual proprietariness which attempts to provide an understanding of intimate femicide by explaining the behaviour of the male perpetrator. Wilson & Daly (1992) argue that intimate femicide is an extreme manifestation of male sexual jealously and "proprietariness" which is linked to the notion of ownership and a sense of entitlement. The act of killing the female partner is a means to control her, viewed as better than losing her to another (Wilson & Daly 1992). From a psychological perspective Dutton (1996) draws on attachment theory, proposing that the borderline/ dysphoric personality is most at risk of killing his partner. This personality type has experienced emotional rejection in childhood and his fear is abandonment due to his "anxious" attachment style (Dutton, Starzomski, & Ryan 1996). It is further suggested that this personality type is not necessarily physically violent but is psychologically abusive.

1.2.8. Theories on Intimate Femicide-Suicide

Although a small proportion of men commit suicide after killing an intimate partner there has been some theory development in this area. One of the theories on intimate femicide-suicide suggests that it is a distinct act which differs from both female homicide and intimate partner femicide (Marzuk, Tardiff, & Hirsch 1992). This difference is based on the short period between killing of the female and committing suicide, they are therefore not coincidental, but occur after careful planning (Marzuk, Tardiff, & Hirsch 1992). From a psychological perspective it is hypothesised that intimate femicide-suicide is linked to relationship stressors, such as separation, which result in depression and morbid jealousy with elements of delusion (Rosebaum 1990). Killing an intimate partner results in immense guilt and remorse for the perpetrator, thus suicide is viewed as the only way out.

Literature on the underlying factors associated with intimate femicide-suicide is limited, with initial work proposing that depression was a key factor, with 75% of perpetrators clinically depressed at the time of the killing (Rosebaum 1990). However this psychological explanation masks the social dynamics involved in such murder-suicides. A population based US case-control study has shown that intimate partner violence is the leading factor associated with intimate femcide-suicide (Koizol-McLain et al. 2006). Other factors associated such as relationship breakdown, particularly estrangement, has also been found to be associated with intimate femicide-suicide (Bourget, Gagne, & Moamai 2000; Easteal 1994;Koizol-McLain et al. 2006;Milroy, Dratsas, & Ranson 1997; Morton et al. 1998). Lund & Smorodinsky (2001) in a case control study comparing intimate femicide-suicide to intimate femicide- without suicide found that they had different characteristics and possibly had different etiologies. It is however argued that traditional explanations such as remorse, depression and psychopathology of the perpetrator do not explain why it is mainly men who commit suicide after killing an intimate partner (Dawson & Gartner 1998). Emerging theories suggest that "pathological possessiveness" by the male intimate partner is linked to jealousy and /or paranoia of losing his partner (Dawson & Gartner 1998). Dawson (2005) explored the role of premeditation over a 20-year period drawing on a sample of intimate femicides. This study found that premeditation was present in the majority of cases thus holding important implications for prevention of such deaths (Dawson 2005). Premeditation suggests that there was a planning process whereby the man made the conscious decision to end both their lives, this act thus being a final act of control.

Our understanding of men who kill an intimate partner is limited. Studies on intimate femicide provide us with little insight into the social construction of men's use of violence. Dobash et al (2009) tested the notion that such murders happen "out of the blue" by comparing men with no previous convictions with men who had a previous conviction (not restricted to previous convictions for violence towards a partner or others but included a conviction for any type of criminal offence) and found that the men without a previous conviction were not that different with regard to previous use of violence in their intimate relationship. Furthermore, they report that the two groups showed no difference in their levels of remorse and empathy for the victim and they conclude that this is due to how they view the position of women (Dobash, Dobash, & Cavanagh 2009). They propose that gender is an important element in such murders, therefore requiring a feminist analysis (Dobash, Dobash, & Cavanagh 2009). Their analysis however falls short and does not continue to provide such an analysis. It is therefore important in our conceptual understanding of men as perpetrators to draw on the broader body of literature on men's violence in intimate relationships which can inform a gendered understanding of intimate femicide.

1.2.9. Challenges in comparing research on intimate femicide

Studies on intimate femicide have predominantly been conducted in developed settings utilising crime data bases. The use of such data bases pose limitations, with misclassification of cases, incomplete information and missing data being a threat to the reliability of findings (Campbell et al. 2007; Paulozzi et al. 2001). Another shortcoming in femicide research is the comparability of data due to the absence of standard definitions of femicide (Widyono 2009). Given these limitations these studies have provided us with valuable insights in developing our understanding of the nature of intimate femicide albeit from developed a

settings perspective. Establishing universal definitions and exploring alternate methodologies for resource poor settings can have utility in advancing a global understanding of intimate femicide.

1.2.10. Prevalence of intimate femicide

Globally there have been few national intimate femicide studies to describe the magnitude of the problem. Studies designed to establish the prevalence of intimate femicide, have primarily been surveillance studies utilizing data from police homicide databases and supplemental homicide reports (Adinkrah 1999; Campbell et al. 2003; Mouzos & Makkai 2004; Puzone 2000; Shackelford & Buss 2000; Wilson & Daly 1993; Wilson, Johnson, & Daly 1995). Other studies have collected data from medical examiner or mortuary records as well as police data (Arbuckle et al. 1996; Moracco, Runyan, & Butts 1998).

One of the first populations based surveys in the United States using FBI supplemental homicide reports reported a female spousal homicide rate of 1.8/100 000 married persons (Mercy & Saltzman 1989). Using police homicide databases Wilson and Daly (1993), compared rates of intimate femicide across Canada (4.0/100 000 married persons), New South Wales (3.5/100 000 married persons) and Chicago (6.5/100 000 married persons). Using medical examiner data a surveillance study in new Mexico established that 46% of women were killed by an intimate partner, an overall female homicide rate of 4.3/100 000 population, but only report intimate femicide rates by race (Arbuckle et al. 1996). In Australia using data from the National Homicide Monitoring Project, it was found that 60% of women were killed by an intimate partner, however they only reported a female

homicide rate of 1.4/100 000 population (Mouzos 2001). A study in Israel that used police files, court records and media reports, established a rate of 0.25 /100 000 population (Landau & Rolef 2001). In North Carolina (US) using medical examiner and police data, 50% of women were killed by an intimate partner with a rate of 3.5/100 000 women aged 15years and older (Moracco, Runyan, & Butts 2003). In a review of homicides (1995-1999) in the United Kingdom it was found that 44% of female homicide victims were killed by an intimate partner, no rates were reported (Brookman & Maguire 2004). Using the FBI supplemental homicide reports for a 20 year period (1976-1995) it was found that 34% of adult women were killed by an intimate partner. The study explored trends over the period and concluded that intimate femicide was declining from 1.79/100 000 spousal homicides 1976 to 1.05/100 000 spousal homicides in 1995 (Puzone 2000). In another review (1981 – 1998) also using FBI supplemental homicide reports, Paulozzi and colleagues (2001) reported an intimate femicide rate of 1.43/100 000 women (excluding those killed by ex-boyfirends), and also concluded that rates were decreasing over the period reviewed. Similar declines have also been reported for Canada, with a 25 year review of data (1976-2001) showing a 51% decline in spousal homicide rate from 1.65/100 000 to 0.8/100 000 (Dawson, Bunge, & Balde 2009). It is argued that this reduction in intimate femicide for these countries have been associated with an increase in the availability of domestic violence services, changes in legislation on intimate partner violence as well as changes in attitudes towards such offences by the criminal justice system (Campbell et al. 2007; Dawson, Bunge, & Balde 2009). In addition, it has also been established that with an increase in gender equity, measured by the women's socioeconomic status as well as level of education, rates of intimate femicide has decreased in Canada (Dawson, Bunge, & Balde 2009).

1.2.11. Prevalence of Intimate Femicide-Suicide

Homicide followed by suicide is an uncommon occurrence, yet when it happens it is most likely to occur when there is an intimate relationship between the perpetrator and his victim (Dawson 2005, Kozoil-McLain et al 2006). Suicide following the killing of an intimate partner is thus a distinctive feature of intimate femicide, with a prior history of intimate partner violence found to be an associated factor (Kozoil-McLain et al 2006). In the few studies that have explored intimate femicide-suicide, this phenomenon has emerged as closely linked to intimate femicide. A disproportionate number of perpetrators' who kill and subsequently take their own lives are current or past male intimate partners of victims (Easteal 1994). A gap in the knowledge on intimate femicide-suicide was noted as rates have only been reported in a North Carolina study (US) with a range of 0.67 – 1.06 per 100 000 women for a five year period, 1988-1992(Morton et al. 1998). All other reported rates refer to homicide-suicide which include the killing of both men and women, and are thus not comparable.

1.2.12. Injuries and Intimate Femicide

The health burden from intimate partner violence is well documented with acute physical injuries ranging from minor bruises and abrasions to severe injuries which can result in death (Campbell 2002; Ellsberg et al. 2008).The WHO study on violence against women estimate that as much as 55% of women who experience violence in an intimate relationship has been injured (Ellsberg et al. 2008). In the United States it has been estimated that 28% of women will seek medical care due to injuries caused by intimate

partner violence (Tjaden & Thoennes 2000). Furthermore a study in 11 cities in the United States found that 40% of women who were killed by an intimate had sought medical care in the year prior to their death (Sharps et al. 2001).

Studies on intimate partner violence and injuries have predominantly focused on acute injury patterns when a woman enters a hospital's emergency department (Muelleman, Lenaghan, & Pakieser 1999; Perciaccante, Ochs, & Dodson 1999; Sheridan & Nash 2007). These studies have shown that there are certain injury types which are more common in cases of intimate partner violence than women injured by other causes and can be used as a screening tool to identify victims of intimate partner violence with good sensitivity and specificity (Crandall, Nathens, & Rivara 2004; Muelleman, Lenaghan, & Pakieser 1999; Perciaccante, Ochs, & Dodson 1999; Petridou et al. 2002). Injuries to the head, neck and face as a result of blunt force trauma have consistently been found to be associated with intimate partner violence, with an increase likelihood of multiple injuries, locations and mechanisms (Crandall, Nathens, & Rivara 2004; Petridou et al. 2002; Sheridan & Nash 2007). Furthermore attempted strangulation has been found to be emerging as an important risk factor associated with intimate partner femicide (Glass et al. 2008).

While injuries are common in intimate partner violence there is a lack of information on the association between mechanism of injury, injury patterns and intimate femicide (Sheridan & Nash 2007). Studies in the United States have shown that firearms deaths and strangulation are very common as a mechanism of death in intimate femicide (Campbell et al. 2003; Glass et al. 2008). The mechanism of death in intimate killings is somewhat different in United

Kingdom where it is more common to be killed by a sharp instrument or strangulation, reflecting restrictions on gun-ownership in the region (Aldridge & Browne 2003).

Little is known about the mechanism of death and injuries in intimate femicide in South Africa. Intimate partner violence, although it has been receiving increasing attention, in some instances can remain "hidden" and the cause of death can be missed due to it happening within the home and police not asking about a history of intimate partner violence as a routine part of their investigation. Developing an understanding of cause of death and related injury patterns in cases of intimate femicide in South Africa can assist with forensic investigations and strengthen the medico-legal management of such cases.

1.2.13. Dynamics of Intimate Femicide

Internationally, the past decade has seen an emergence of published literature on risk factors associated with intimate femicide. Risk factors have primarily been explored through the use of a case control design, using homicide databases to identify cases and controls, women who are similar as the "cases", using experience of intimate partner violence as one of the selection criteria. Controls were identified through services for intimate partner violence, via random telephonic calls or through violence against women survey data (Campbell et al. 2003; Wilson, Johnson, & Daly 1995).

i. Violence and its relationship with intimate murders

A history of intimate partner violence has consistently been shown to be associated with intimate femicide (Arbuckle et al. 1996; Campbell 1992; Campbell et al. 2003; Moracco, Runyan, & Butts 1998; Moracco, Runyan, & Butts 2003). Based on the notion that intimate

femicide is the most extreme form of intimate partner violence, it is important to explore the gendered nature of this act. The act of killing a female partner does not occur "out of the blue", it is most likely to happen after a long standing history of violence, which could be both physical and psychological in nature. Locating men's use of violence within a feminist discourse, it is construed as a product of gendered power differentials with violence construed as a means to control; or used when striving for control, which may or may not be realised, which might not be a conscious motivation (Sev'er 1997). Intimate femicide is therefore considered to be an extreme means of taking control when a man perceives he has either lost control in the relationship, or fears losing control in order to maintain a position of power within the context of a violent intimate relationship (Campbell 1992; Smith, Moracco, & Butts 1998; Wilson & Daly 1992). Nevertheless, intimate femicide in popular media is often projected as "losing self-control", when in many respects it is an attempt to gain control when there is a fear of losing his partner, whether this fear is real or not. In addition the act of killing an intimate partner may also be linked to other emotions such as extreme anger at the women for transgressing her perceived role whether this is real or imagined, for example suspicion of having an extra-marital affair. The violence is seen as justified punishment for her "betrayal" and by defending his honour with the use of violence is accepted in some cultural contexts (Wood et al 2008).

ii. Age

Studies have shown that the age of a woman is an important factor, with younger women more likely to be at risk of intimate partner violence (Mercy & Saltzman 1989; Moracco, Runyan, & Butts 1998; Mouzos 1999; Paulozzi et al. 2001; Shackelford & Buss 2000); and rates peaking between the ages of 20-25 years (Mouzos 1999; Paulozzi et al. 2001;

Shackelford & Buss 2000). In addition, age disparity between couples, with the male partner being older, significantly increases a women's vulnerability to intimate femicide (Mercy & Saltzman 1989; Moracco, Runyan, & Butts 1998), was found in these studies but not in others (Campbell et all. 2003). Having the man a bit older than his female partner is normative in intimate relationships, it might be more important to explore how substantial the age difference should be to increase this risk. Nevertheless, age difference between women and their partners have also been found to be a risk for intimate partner violence among young women in South Africa (Jewkes et al. 2006; Pettifor et al. 2005). An age difference might reflect a controlling and exploitative dynamic within relationships. Wilson and Daly (1992) from an evolutionary psychology perspective argue that the much older male partner fear that the younger female partner might leave him for a younger "gene pool".

iii. Socio-economic status

Paulozzi et al (2001) report an increased rate of intimate femicide among African Americans in the United States. However, Campbell et al (2003) found that race was not independently associated with an increased risk of intimate femicide, but this study found that unemployment among perpetrators increased the risk for such killings. This is suggesting that it is rather socio-economic status than race that plays a role. This connection is possibly embedded in the relationship between poverty and its associated stresses which increases the risk for intimate partner violence (Jewkes 2002). It has been argued that the relationship between poverty and violence is influenced by male identity, as shown in a study with structurally disempowered young men in an urban slum in New York, who reshaped their

ideal of masculine "success" to that of a hyper-masculine, violent masculinity (Bourgois 1996). Intimate femicide has been reported in interracial marriages compared with intra-racial marriages in the USA (Mercy & Saltzman 1989), but not found in other studies (Campbell et al 2003), suggesting that this relationship is complex.

iv. Relationship dynamics

Relationship state (ex/current) and status (wife/girlfriend/cohabiting) were also found to be important factors associated with these homicides (Brownridge 2004; Campbell et al. 2003; Moracco, Runyan, & Butts 1998; Wilson & Daly 1993; Wilson, Johnson, & Daly 1995). Divorced or separated women are at heightened risk of being killed by an intimate partner followed by women in cohabiting relationships, compared to women who are married (Dawson & Gartner 1998; Garcia, Soria, & Hurwitz 2007; Wilson, Johnson, & Daly 1995). The increase in risk at the time of divorce or separation might also be related to his perceived loss of control when a man's partner threatens to separate or leave. This act is experienced as a threat to his masculine identity, this combined with aspects of jealousy and notions of ownership and entitlement, legitimizes the use of physical violence.

Stalking, defined as being followed or spied on by an ex or current partner, is also associated with an increase in likelihood of subsequent intimate femicide, with ex-partners more likely to stalk than current partners (Campbell et al. 2003; McFarlane et al. 1999; McFarlane et al. 2002). A link between stalking and controlling behaviour has been confirmed (Tjaden & Thoennes 2000), suggesting that stalking is rather an extreme form of control and is thus a form of psychological abuse in an intimate relationship. From a psychological perspective it

is postulated that stalking and obsession are related (McFarlane et al. 2002), with stalking being an obsessive behaviour linked to attempts to control the female partner's movements. The combination of extreme control and obsessive behaviour in intimate relationships appears to increase the risk for lethality in such relationships.

v. Alcohol as a factor in intimate femicide

Alcohol use has emerged as a factor associated with both intimate partner violence and consequently, intimate femicide (Sharps et al. 2001). Violence often occurs in intimate relationships where men are heavy drinkers (Grisso et al. 1999; Kyriacou et al. 1999; Lipsky et al. 2005). Studies in the United States on victim and perpetrator use of alcohol in relation to intimate femicide suggest that there are gender differences in the pattern of alcohol use (Moracco, Runyan, & Butts 1998; Sharps et al. 2001). Most of the female victims had negative blood alcohol concentration toxicology reports, while more than half of male perpetrators had been intoxicated.

vi. Gun access and ownership

Gun ownership, and access to guns in the home, has been found to be significantly associated with intimate femicide, with access to guns substantially increasing the risk of lethality of an assault (Arbuckle et al. 1996; Campbell et al. 2003; Kellermann, Rivara, & Rushforth 1993; Moracco, Runyan, & Butts 1998). Previous threats with a weapon have also emerged as a significant factor associated with intimate femicide (Campbell et al. 2003). In addition, the availability of firearms in the home has been found to increase the likelihood of an intimate femicide (Arbuckle et al. 1996; Bailey et al. 1997; Campbell et al. 2003). Little is known types about weapons used when a woman is killed by an intimate partner in South Africa. Studies on intimate partner violence in South Africa has shown that women are

threatened and attacked by intimate partners with guns in non-lethal episodes (Abrahams et al. 2006; Jewkes et al. 2000a).

1.2.14. Intimate femicide in South Africa

Prior to this study the only other research on intimate femicide in South Africa was conducted in Gauteng by the non-governmental organisation People Opposing Women Abuse (POWA). This study reviewed newspaper reports and inquest court records for the region from 1993 to 1995 and concluded that a woman is killed every six days by an intimate partner in Gauteng (Vetten 1996). Despite the limitations of the study design the findings were used extensively in advocacy campaigns in South Africa and in many ways highlighted the need for a systematic enquiry into the problem of intimate femicide.

The above review of the literature illustrates that scientific research in the area of intimate femicide is just emerging in South Africa. Very little has been known about this phenomenon in the country as police statistics do not provide the necessary information to monitor the trends of intimate femicide. The study by Vetten (1996) has shown us that the murder of a woman by an intimate partner is a problem that requires systematic investigation.

A national female homicide study was therefore designed to develop an understanding of the epidemiology and factors associated with intimate femicide in South Africa. This study was designed as a retrospective mortuary-based study, using a novel approach to firstly identify all female homicide victims via mortuary registers and then to identify victim

perpetrator relationships through a process of follow-up interviews with the police. This thesis will be drawing on data collected for this national female homicide study, as well as a qualitative study with incarcerated men who have been imprisoned for the killing of an intimate partner.

The first four papers presented in this PhD examine different aspects of female homicide from the quantitative data set, with the aim of deepening our understanding of intimate femicide in South Africa. I was overall responsible for the data collection; data management and cleaning; and initial analysis which was presented as a policy brief (Mathews et al. 2004). The writing of the overall analysis was lead by Abrahams and colleagues (2009), and I am a co-author and am therefore presenting this as paper I. I not only played an important role in the research process, but also contributed to the structure of the paper, its analysis and commented on drafts of the paper. This paper is thus presented as a supplementary supporting paper in this thesis as it provides an overview of female homicide and intimate femicide in South Africa. Paper II, II and IV presents further analysis of different aspects of the epidemiology of female homicide. Paper IV was initially analysed and presented as a mini-dissertation of 20 000 words, towards a Masters in Public Health at the University of Cape Town (2005), entitled Intimate Femicide-Suicide in South Africa: The epidemiology of male suicide following the killing of an intimate partner. The paper which forms part of this thesis was reanalyzed for peer reviewed publication. The logistic regression model was redone and the log likelihood improved. The variable for age of victim and perpetrator was re-coded to reflect standard age categories and the variable of gun ownership was revisited and missing data was included in the model. This strengthened the logistic regression model as we had less missing values in the model and the estimates were thus more robust. In

addition, a population attributable fraction for gun ownership was calculated which was not presented in the mini dissertation. Paper V presents data from an additional qualitative study with men who have killed an intimate partner to explore the social construction of violent masculinities in South Africa. This PhD therefore provides important information on factors that increases women's chances of becoming victims of intimate killings while also furthering our understanding of men as perpetrators which can all inform a prevention strategy. The challenge we face in South Africa is developing evidence-based strategies to prevent the early mortality from interpersonal violence. To date, violence and injury prevention strategies have lacked an integrated national response that takes into account empirical evidence of the contributing factors to violence (Seedat et al. 2009). The findings from this thesis are critical to inform policy and practise on factors leading to the early mortality of women in South Africa.

1.2.15. Aims and Objectives

This thesis presents research on intimate femicide, the most extreme form and consequence of intimate partner violence, and aims to study it from two methodological perspectives. Two separate studies have been conducted to meet these aims and objectives. The first aim is to describe the incidence and patterns of female homicide and to compare the epidemiology of intimate femicide with other female homicides in South Africa. The methods of this quantitative study are presented as Study One, the National Female Homicide Study. Secondly, methods for Study Two are presented, with this study utilising qualitative ethnographic methods to explore the social construction of violent masculinities.

Specific objectives

1. To describe the epidemiology of mortality of women from intimate partner violence. (Paper I)
2. To describe the incidence of female homicide, with reference to cause of death. (Paper II)
3. To describe the injury patterns of female homicide victims with reference to cause of death. (Paper II)
4. To assess autopsy standards through an assessment of injury and wound description. (Paper II)
5. To describe the patterns of blood alcohol concentration (BAC) at the time of death for female homicide victims. (Paper III)
6. To explore the factors associated with having an elevated BAC at the time of death for female homicide victims. (Paper III)
7. To examine the incidence and patterns of intimate femicide–suicide in South Africa. (Paper IV)
8. To describe the factors associated with an increased risk of suicide after intimate femicide. (Paper IV)
9. To explore how childhood factors influence the construction of masculine identity among men who killed an intimate partner. (Paper V)

CHAPTER TWO

METHODOLOGY

2.1. Definition of terms

Female Homicide - The unlawful and intentional killing of a female person. **Intimate Femicide (IF)** - The killing of a woman by an intimate partner. This includes the woman's husband, boyfriend (dating or co-habiting), ex-husband (divorced or separated) or ex-boyfriend, same sex partner or a rejected would-be lover.

Non-Intimate Femicide (nonIF) – The killing of a woman by someone other than an intimate partner.

Intimate Femicide-Suicide (IF-S) – An intimate femicide followed by the suicide of the perpetrator within a week of the homicide.

Intimate Femicide- Non Suicide (IF-nonS) – The killing of a female by her intimate partner without subsequent suicide of the perpetrator.

Family Murder – The killing of an intimate partner and children followed by suicide of the perpetrator

Blood Alcohol Concentration (BAC) – The concentration of alcohol in a person's blood measured in grams /100ml (in South Africa) and commonly used as a measure of intoxication.

2.2 Study One (Papers 1-4)

2.2.1 The Setting

In South Africa the Births and Deaths Registration Act (Republic of South Africa 1992) requires that all deaths undergo a certification process, through the issuing of a death certificate by a medical practitioner and that all deaths be registered with the Department of Home Affairs. When a death is due to an unnatural cause (i.e. suicide, homicide, poisoning etc.), the Inquest Act (Republic of South Africa 1959) stipulates that a post mortem be performed to determine the cause of death. In this event a post mortem examination has to be performed at the nearest medical legal laboratory, hereafter named 'mortuary', as they are commonly known in South Africa. The Inquest Act (Republic of South Africa 1959) specifies that the South African Police Service fulfils the medico-legal function and has to ensure that a post mortem examination is completed to assist in determining the cause of death, and to investigate who is responsible for the death. At the time this study was conducted mortuaries were managed by the police. A pathologist or district surgeon performed the post mortem examination and completed a post mortem report, with the original filed at the mortuary and a duplicate copy in the police docket. The police issued a death certificate and similar details were entered in a death register, maintained at each mortuary. All unnatural deaths must undergo a police investigation, and based on this investigation a case will either go through a criminal court proceeding or an inquest court inquiry, as it is only a judicial officer who can decide who is responsible for the death.

The majority of unnatural deaths therefore proceed through the medico-legal system and medico-legal records are a relatively complete source of data for research on murder of adults. Mortuaries are mandated to keep death registers which contain details including

name, age, sex, date and time of death, etc. A secondary source of data is the post mortem report which is filed both at the mortuary and in the police docket.

2.2.2 Study Design

The study was designed as a national retrospective mortuary-based study of female homicide. Data was collected from a random sample of mortuaries in South Africa for 1999. The study utilised routine data from death registers, to identify all cases of female homicide for 1999 at the sampled mortuaries. Data was firstly collected through the mortuary records i.e. death registers and mortuary files. All cases identified at mortuaries were then followed up via a telephonic interview with the investigating officer, commanding officer or a record review, to determine the victim-perpetrator relationship and the legal outcomes of the cases, as this data is not routinely available. Lastly post mortem records were reviewed and pathology data was extracted for data collection.

2.2.3 Population

The study population was all women aged 14 years and older, who had died as a result of a homicide during the year 1999, and had a post mortem performed at a mortuary within South Africa. The age of 14 years was used in the study as the age cut point, as our primary aim was to determine the incidence of intimate partner homicide and very little dating and sexually intimate relationships occur before girls are 14 and thus they are not at risk of intimate partner homicide before this age.

2.2.4 Sampling

Sampling was conducted by using stratified cluster sampling techniques. Mortuaries were stratified based on the number of post mortems conducted annually, with each mortuary

viewed as a cluster. Mortuaries were randomly selected within a stratum, proportional to the number of mortuaries in each stratum.

2.2.5 Sample

The year 1999 was selected as most cases would have been through the court process at the time of data collection and records would be accessible for research. The date and time of death was taken as the period for sampling i.e. deaths that occurred between 00:00 hrs 1st January 1999 and 24:00 hrs 31st December 1999. The sampling frame was a list of mortuaries prepared for a Department of Health Audit of Medico-Legal Services in 1998 (Department of Health 2000), which I updated for 1999. Mortuaries were stratified based on the number of post-mortems performed for 1999. Three strata were developed, namely up to 500 bodies (small mortuary), 501 to 1500 bodies (medium mortuary) and above 1500 bodies (large mortuary). A nationally representative sample of mortuaries was drawn with the assistance of a statistician. The sample size was calculated on the assumption that the standard deviation in the number of intimate femicides between mortuaries was proportional to the standard deviation of the number of bodies per annum between mortuaries. The approximate ratio of allocation between the three strata was 8:5:12 (8 large mortuaries, 5 medium mortuaries and 12 small mortuaries), which was based on optimal allocation, fitting a sample of 25 mortuaries (Foreman 1991).Based on the assumption that the number of intimate femicides is approximately 5% of all homicides, this would give a precision (standard error) of approximately 0.15%, thus the confidence intervals would have an approximate width of 0.3%. The total of 25 mortuaries was therefore assumed to be sufficient for the required precision for a national female homicide study.

The sample of mortuaries was randomly chosen proportional to the number of mortuaries in each stratum. Every 2nd mortuary in the Stratum 1 (large), every 7th mortuary for Stratum 2 (medium) and every 14th mortuary starting at the 5th mortuary for Stratum 3 (small) were selected.

Table1: The sampling fraction based on the operating Medical Legal Laboratories (MLL) in South Africa in 1999

Number of autopsies per annum	Number of MLL (N)	Sample (n)	Sampling Fraction (%)
>1499	15	8	53.3
1499 – 500	34	5	14.7
<500	176	12	6.8
Total	**225**	**25**	**11.1**

2.2.6 Process of Case Identification

This study had a 100% response rate, as access to all sampled mortuaries was obtained and all sampled mortuaries were included in the study. There were then three stages of case identification as described below:

i. **Identification of Female Homicide Cases**

All sampled mortuaries were visited by the field workers to identify cases of female homicide via death register(s) kept for the year under investigation. At three small mortuaries, no death registers were kept for the study period, while another mortuary had an incomplete register for this period. At the latter mortuary, the district surgeon serving the mortuary made his diary available in order to identify cases of female homicide. For these four mortuaries follow-up visits to the police stations served by the mortuary were

undertaken. The crime record books and data bases of the police station were reviewed to ensure identification of all cases for the study period.

All identified cases at mortuaries were followed-up with the police, but in 6.9% of cases no police case could be traced. Cases were only included in the study once it was established with the Investigating Officer that it was a homicide. Where the police were unable to clearly define the case as a homicide, the case was discussed during research team meetings. Only twenty four such cases were discussed at team meetings to reach a decision whether the case should be included as a homicide or dropped from the study. This decision was taken based on available information from the post mortem report in conjunction with the forensic pathologist's expert knowledge.

ii. Identification of Intimate Femicide Cases

The categorisation of cases into intimate femicide and non-intimate femicide was important for this study. Identity of the perpetrator and circumstances around the homicide was critical for this process. The victim-perpetrator relationship was obtained through an interview with the police. Cases which were definite homicides, but where the perpetrator-victim relationship could not be established (for example when the perpetrator was unknown) were defined as unknown homicide. A small proportion (0.34%) of cases n=11 were categorised as suspected intimate femicide. These were cases where the investigating officer strongly suspected the intimate partner, but did not have sufficient evidence to lay a charge. As this was a small percentage of the cases it was merged with the definite cases for this analysis.

iii. Identification of Intimate Femicide-Suicide Cases

One of the study aims was to establish the incidence of intimate femicide-suicide. A further classification into intimate femicid- suicide and intimate femicide non-suicide was therefore necessary. A case was classified as intimate femicide-suicide if the perpetrator committed suicide within a week of the homicide. Intimate femicide suicide cases were established from the police interview or police record review, with 19.4% of intimate femicide cases classified as intimate femicide suicides. Classification bias was minimised through the use of two data sources: data from the investigating officer and outcome form the inquest court inquiry.

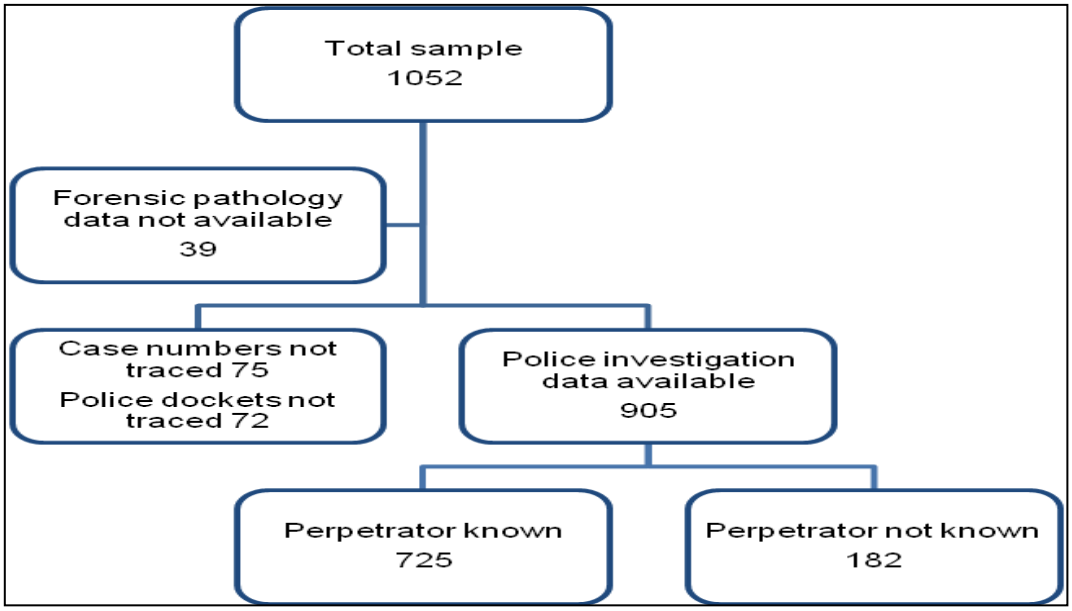


Figure 1: Flow Diagram of the sample from 25 medical legal laboratories (Mathews et al 2008, Abrahams et al 2009)

2.2.7 Data Collection

Data were collected from 2002–2003 using a pre-tested data collection sheet. A standardised three-part data capture sheet was designed for data collection (Appendix 1) The first part of the data capture sheet captured mortuary data, the second part gathered

police data and the third part collected pathology data. The following categories of variables were included in the questionnaire:

i. Data from Mortuary

- When the homicide occurred; date, day of week and time of homicide.
- Victim demographic information including age and race
- Whether blood for alcohol was taken and alcohol level result

Ii. Data from Police

- Victim socio-economic status was established by using two measures (employment category and type of housing)
- Perpetrator demographic information: age, race, employment category,
- Circumstances relating to the murder: scene of homicide, legal or illegal gun ownership of perpetrator, alcohol and drug problem use of perpetrator and whether the perpetrator committed suicide after the homicide.
- Establishing victim-perpetrator relationship to categorise the form of homicide.
- Number of victims involved in the killing, whether the perpetrator committed suicide, whether it was murder-suicide or a family murder,
- Previous history of intimate partner violence in the relationship.
- Previous contact with the police regarding intimate partner violence and protection order application, previous use of support systems and medical care. These are vital in identifying risks for women in violent relationships. (Data not used for this thesis).
- The legal and non-legal outcomes of cases: whether the perpetrator was convicted, type of sentence passed, previous charges of the perpetrator, (data not used for this thesis).

- Events leading to the victim's death: relationship status at the time of the homicide, if the couple was separated – who initiated the separation and identifying any events associated with the homicide.
- The quality of the police investigation: whether an investigating officer had visited the scene of the crime, whether the pathologist had visited the scene of the crime, whether specimens were taken and what happened to them, and whether photographs were taken as evidence (data not used for this thesis).

iii. Data from Pathology Report

- Variables included in the pathology data sheet were on types of injury, location of injury, evidence of sexual abuse, pregnancy and mechanism of death
- Quality of post mortem reports was assessed by the forensic pathologist
- Type of specimens collected as evidence

The mortuary data were gathered via a record review of the death register and mortuary files. The second data collection process, obtained data from the police. The preferred method was through telephonic interviews with the investigating officer (53.7%), but when this was impossible an interview with a secondary police source (27.1%) or a record review (19.2%) was conducted. The pathology data which was abstracted from a photocopy of the post mortem report that was collected at the time of the mortuary visit. A forensic pathologist (Prof Lorna Martin) extracted the data, if a blood alcohol specimen was taken the result was obtained from either the autopsy report or police data, and if not available, it was requested from the two national forensic laboratories. Blood alcohol concentration (BAC) data was only available for the Western Cape Province as BAC results for the other

regions were destroyed prior to data collection. (see paper III for a more detailed description of this variable). The forensic pathologist also assessed the standard of the autopsy report based on the documentation of injuries. This was based on international standards for the writing up of autopsy reports and guidelines developed by the South African National Department of Health for the Performance of Post mortems (known as the GW 7/71). (see methods for paper II for a detailed description).

2.2.8 Validity and Reliability

To maximise the reliability of the instrument a standardised data collection sheet was used. The data collection sheet was developed by incorporating previously used instruments i.e. [1]National Injury Mortality Surveillance System (NIMSS) data collection form, the rape homicide data collection form (Martin 1999) combined with input from experts on the type of data available from mortuaries and police. Content validity of the questionnaire was ensured through an extensive process of reviewing published literature and a process of consultation with experts in the field. The questionnaire was also circulated to experts in the field for comments to ensure content validity.

A pilot study firstly tested face validity of the questionnaire to determine whether the questions were applicable to the South African setting. It also tested the logistics related to the identification of cases via a mortuary and the follow-up interview with the investigating officers. Data were collected at two sites (Salt River and Malmesbury Mortuary) for a three-month period for 1998. These two sites were selected because of the different systems

[1] NIMSS- is a sentinel mortuary based study capturing information of fatal injuries at 21 mortuaries across South Africa, mainly in urban areas.

(private and public) operating at the two mortuaries. Following the pilot study, the data collection sheet was adjusted; for example it was found that police officers collected limited information on previous violence in intimate relationships, and items on stalking were removed from the data collection form. The pilot also made us aware of the difficulties in tracing investigating officers, and the logistics of setting-up of interviews with them, therefore an alternate data collection process i.e. review of dockets, or the interviewing of commanding officers was introduced. This process strengthened both face validity and content validity of the data collection tool.

To enhance the reliability of the classification of cases, clear operational definitions of categories were developed at the onset of the research. A clear set of questions were used to assist in determining the outcome of homicide and type of homicide. Team meetings were held to discuss and categorise difficult cases, where police data was insufficient to classify a case. This assisted in reducing misclassification.

To validate police data obtained from the investigating officer on the outcome of cases, a validation study was done that followed-up the court records of 25 random cases from the Salt River mortuary. This validation exercise was embarked upon as the outcome of a court case was reported by the police after the criminal investigation, and could have been erroneously recorded in police records. The validity study found that 1 out of the 25 cases yielded a difference in court outcome with at the time of gathering police data the case was still open us a culpable homicide but when conducting the validation study the case had been withdrawn as witnesses has disappeared. This showed a 96% agreement, with a Kappa of 0.94 ($p < 0.000$). This validation study suggested that the data collected from a secondary

source, an investigating officer was likely to be both substantially reliable and valid. A single forensic pathologist was responsible for the data extraction and assessment of the pathology reports. This made the assessment of pathology reports highly consistent across the dataset. Furthermore, standardised measures of assessing post mortem quality were applied in an attempt to reduce bias of the assessment.

2.2.9. Project Management

My role in the study was that of project co-ordinator. I started working on the study after the initial conceptualisation of the study design, proposal development and development of first drafts of the data collection tools. I implemented the pilot study and assisted in the revision of the data collection tools under the supervision of both Prof Rachel Jewkes and Dr Naeemah Abrahams. I was responsible for the implementation of the study, including negotiating access to mortuaries and the police data. I collected most of the data at mortuaries, conducted the majority of interviews with investigating officers and where they were done, most record reviews. The data collection was supervised by Dr Naeemah Abrahams. Once data was entered I assisted with data cleaning with the guidance of Dr Naeemah Abrahams. Both Prof Rachel Jewkes and Dr Naeemah Abrahams provided me with direction on the initial strategy for data analysis. Two statisticians gave support to the study, Dr Jonathan Levin assisted with the selection of the sample while Dr Carl Lombard provided guidance on the statistical analysis. I was responsible for conducting the analysis and interpretation of the data as well as the scientific writing of the papers that I am presenting as part of my PhD, with close supervision from both supervisors.

2.2.10. Data Analysis

Stata version 8 (STATA 2001) was used in the analysis for paper 1, 2 & 4 and Stata version 9 (STATA 2005) was used in the analysis for paper 3.

i. **Paper I**

The overall objective of this paper was to describe the epidemiology of mortality of women from intimate partner violence.

This paper used cases identified at mortuaries and the follow-up information from investigating officers for case ascertainment which was based on victim perpetrator relationship. Mortality rates were calculated overall and presented by age and race, 1996 South African Census Report (Statistics South Africa 1998), adjusted for the year under investigation was used for the denominator in calculating rates. Pearson's chi square test was used to determine significant differences between groups.

ii. Paper II

The overall objective of this paper is to describe the incidence of female homicides and their related injury patterns and to assess autopsy practices in South Africa.

Data extracted from all autopsy reports were used as the primary data for analysis. An overall sample of 1,052 female homicides was identified for the year 1999. Autopsy reports could not be traced in 39 cases therefore this analysis is based on 1,013 female homicide cases. Cause of death in this analysis was categorised as gunshot wound, sharp force injury, blunt force injury, strangulation and other which included asphyxiation, poisoning,

drowning, fire and undetermined deaths. To determine the standard of the autopsy report a score ranging from 1=<25%, 2=25-50%, 3=51-74%, 4=76-99% to 5=100% was assigned based on injury documentation. The documentation was assessed based on: description of the location of injuries, pathological description of injuries and whether wound dimensions were specified. The assessment was done during the process of transcription by the forensic pathologist on the team using standard wound description guidelines (Brouwer & Burger 2006).

The sampling, stratification and weighting of the mortuaries was taken into account in the analysis of data. This allowed for the calculation of mortality rates by cause of death using population estimates from the 1996 South African Census after adjusting for annual population growth (Statistics South Africa 1998). Frequencies and 95% confidence intervals (CI's) were used to describe victim and perpetrator socio-demographic characteristics and injuries patterns by cause of death. Chi square tests were conducted to check for significant differences between groups.

iii. Paper III

The objective of this paper is to describe the patterns of blood alcohol concentration (BAC) at the time of death for female homicide victims and to explore the factors associated with having an elevated BAC.

BAC data was available only for the Western Cape Province as BAC results for the other regions were destroyed before data collection. This article is based on an analysis of female

homicide cases from the Western Cape Province only. A total of 182 cases were identified via death registers; no blood alcohol was taken in 24 cases, blood alcohol results were missing in 4 cases, and 1 post-mortem report was missing. An analysis of this BAC missing group (*n* = 29) showed that the demographics were similar to the rest of the sample, and this group was excluded from further analysis. This article is based on the other 153 cases. Since this analysis only used data from one province an unweighted analysis was performed.

Comparisons were made between levels of alcohol (below the legal alcohol limit and above the legal alcohol limit) for all cases using unadjusted odds ratios. To handle the non-normal distribution of BAC a non-parametric regression approach was followed and quantile regression using the median was selected (Koenker 2005). The legal limit corresponded to the 45^{th} percentile of the BAC distribution and is therefore very close to the median. Multiple regression analysis was done and the victim characteristics were considered as the co-variates and the estimated coefficients reflect a shift in the number of BAC units from the median BAC with respect to the reference group. 95% confidence limits were estimated for all parameters. The regression model included interactions between co-variates which were identified through exploratory analysis. A tree regression (Brieman et al. 1984) showed the interrelationship between certain type of homicide with employment status as well setting. The final quantile regression model included interactions terms for type of homicide with employment and setting. A further post estimation stratified analysis of the interaction terms was conducted to obtain the differential for intimate and non-intimate homicides of these co-variates.

iv. Paper IV

The overall aim of this paper is to describe the incidence and patterns of intimate femicide–suicide and the factors associated with an increased risk of suicide after intimate femicide.

The analysis of the data took into account the stratification, weighting and clustering of mortuaries in order to derive national estimates. Incidence rates for intimate femicide-suicide were calculated for victims and perpetrators using population estimates from the 1996 South African Census Report (Statistics South Africa 1998), adjusted to reflect the year under investigation. Descriptive statistics were used to compare intimate femicide-suicide and intimate femicide-without suicide cases. Significant differences between the two groups were tested using the Chi Square test. Unadjusted odds ratios and 95% confidence intervals were calculated to describe the association between intimate femicide-suicide and selected variables.

In addition, a logistic regression model was built for the factors associated with intimate femicide-suicide. A backward stepwise model building process was followed. Candidate variables for the model included perpetrator race, victim age, perpetrator age, perpetrator occupation, legal gun ownership, relationship status, events leading to the homicide, primary cause of death and mechanism of death. The final model contained the independent variables that remained significant at ≤0.05 level. Finally the population attributable fraction percent for legal gun ownership and intimate femicide-suicide was calculated using the adjusted odds ratio for gun ownership using the following formula (Mitchell & Benichou 2000).

$$\mathrm{PAR\%} = \frac{\mathrm{Pe}(\mathrm{OR} - 1)}{1 + \mathrm{Pe}(\mathrm{OR} - 1)} \times 100.$$

2.2.11. Ethics

Ethical approval for the study was obtained from the ethics committee at the Medical Research Council (Appendix 2) and from the University of Witwatersrand Research Ethics Committee (Appendix 3). Access to mortuaries was gained through the National Department of Health (Appendix 4) and from each provincial head responsible for mortuaries. The Commanding Officer for each mortuary was also approached to give permission to access the death registers and post mortem reports at each sampled mortuary.

The study was conducted anonymously. Data capture sheets did not collect the name of the victim or perpetrator. Cases were only identified by a research number assigned to them. It was not possible to obtain informed consent from the study subjects because they were deceased. The confidentiality of the victims and perpetrators was ensured at all times.

Permission to access information from the investigating officers was obtained from the National Commissioner of Police (Appendix 5). Prior to the telephonic interview written informed consent was obtained from each investigating officer (Appendix 6). Data gathered from investigating officers were also collected anonymously as the study did not want to influence the possible outcome of a case.

The researcher was also of the opinion that she had an ethical obligation towards the study subjects, murdered women. Where it was found that a homicide had not been investigated, the researcher liaised with the National Department of Police Services to attempt to trace such cases or open dockets where none existed. The researcher also had an ethical responsibility to provide feedback to the stakeholders (South African Police Services & Department of Health) as well as to disseminate the research findings to enhance safety of women. The researcher engaged in a process of disseminating the research findings to different groups of stakeholders in order for the findings to have maximum impact and to benefit South African women and families. Funding was obtained from Womankind Worldwide to use the study findings for advocacy. The study findings were used extensively as an advocacy tool, firstly to place the issue of intimate femicide on the agenda of both civil society as well as policy makers. This was achieved through various meetings as well as a partnership with the Commission on Gender Equality to host a seminar as well using the findings in the Commission's national campaign during the 16 days of activism on no violence against women in November and December of 2005. The study findings were also used extensively to lobby for stricter firearms control through a partnership with the Gun Control Alliance and submissions to parliament for the Firearms Control Act.

2.3 Study Two (Paper V)

The study was qualitative, using in-depth semi-structured interviews. The overall purpose of the study was to explore how men explained their use of violence in their intimate relationship as well as what they perceived to have led to the killing. This aim is however not covered by the paper presented as part of this PhD. The aim of the paper presented in this thesis is; To develop an understanding of how these men came to be who they are, an

exploration of their childhood was included to advance our understanding of pathways to violent masculinities. This PhD will however only address the later objective as it will only be present one aspect of data collected, namely childhood. The paper on childhood factors and their influence on the formation of masculinities, is the first paper to be published from this data set and forms part of this PhD, while other papers from this dataset will follow.

2.3.1 Setting

The study was conducted at two prisons in the Western Cape Province of South Africa. These study sites were chosen for convenience, nevertheless this region also has the highest homicide rate in the country (Altbeker 2008). Both prisons were located in a rural area but accommodated a diverse group of men from both urban and rural settings. Conducting research in a prison setting posed numerous challenges as it had to be conducted within the guidelines of the Department of Correctional Services. Although permission to access correctional facilities was granted, each prison visit had to be arranged well in advance. Even though prior arrangements were made with the liaison person at the facility to see a respondent, this did not guarantee that respondents were available. Interviews thus had to fit into prison routine. This was similar to the experience of Cowburn (2007) in his analysis of engaging with prison culture as a researcher. The requirement to have an escort from the gate to the social work department where interviews were conducted, as well as having all doors locked behind one influenced my sense of safety. These factors increased my awareness that the prison setting influences the perceptions of the world of the men being interviewed.

2.3.2 Sample

A group of men who were convicted for the murder of an intimate partner and were serving time in prison in the Western Cape was identified from the police dockets in the national study. The Department of Correctional Services assisted in tracing these men through their system and two correctional facilities were identified in were potential respondents were incarcerated. A final sample of 20 men was purposively sampled to participate in the study. Half of these men were incarcerated for killing their wife, and half a girlfriend, while one man killed both his wife and daughter and another his wife and step son. The men were aged between 18 years to 51 years of age at the time of the incident with a mean age of 33 years, and between 21 years to 61 years at the time of the interview. Less than half (8) of the men were raised by both parents, 3 men were raised by grandmothers and the rest (9) by a single parent. All the men had attended school, but only one man completed his schooling (matric), with another completing it in while in the army. Nine of the men did not complete junior school, the others progressed to High School, but dropped out by Std 8. More than half of the men (11) had a previous prison conviction, with 8 men having served previous time in prison. Some of the offences committed were when these men were young and they spent time in a reformatory (3) while others had a suspended sentence. They included [2]White (3) and African (2) men, but most men were Coloured (15), and had been raised in both rural and urban settings. The over- representation of Coloured men is characteristic of the demographics of the region as well as general homicide patterns in the Western Cape, as violent crime and homicide rates are very high within this race group (Thomson 2004). The majority (n=12) of the men were serving time in medium security sections of prison at the time of the interviews, while 6 men were in maximum security and 2 men were serving time as juveniles. The men provided consent to access family and

[2] **Race classification based in the "Apartheid' classification with coloured denoting a person of mixed origin**

friends from both their own and their partner's families. An additional group of relative and friends for each case also formed part of the sample. (n=34)

2.3.3 Approach to the interview

I approached this study and my engagement with these men from a feminist standpoint. A critical question this raised for me was, whether interviewing men was a "collusion", compromising the position of women. The work of my colleagues, Kate Wood & Rachel Jewkes (2001) with young men in Umtata and Naeemah Abrahams (2006) with working men in Cape Town, as well as Yandisa Sikweyiya (2007) with men in the Eastern Cape on how men respond to questions on rape in research (Sikweyiya, Jewkes, & Morrell 2007), showed me that research with men who perpetrate violence can yield credible data. The acquisition of such data is important in furthering our understanding of gender based violence, in particular the violent practises of men, which is critical to inform successful prevention strategies. However examining men's experiences and how these influence their violent practises is a fairly new area of research both internationally (Cavanagh & Lewis 1996) and in South Africa.

From the onset it was important to acknowledge that being a woman influenced how these men represented themselves, as well as what they came prepared to talk about. It was also important to recognise that their prison experience and the interview process might have influenced how men represented themselves. Moore (1994) has argued that how we make meaning of the self is influenced by discourses and social practices which form our subjective reality. These men's representations of self nevertheless provided important insights into how their childhood experiences shaped the construction of their identity as

men. Whilst perceived and narrated childhoods may have differed from actual childhood experiences, the approach to data collection enabled many of the circumstances described to be confirmed by other family members. I adopted a strategy of critical engagement using active listening as a tool to gain interesting and useful data (Hearn 1998). I therefore presented myself as interested in their story as "only" they knew what happened. While other researchers suggest the use of challenge as a technique in feminist research with men to obtain "valid" data (Cavanagh & Lewis 1996), I was of the opinion that this could do more damage to the rapport that I felt was important in the interview and opted for probing to explore areas of interest.

Listening was an important aspect of the research process and took place not only in the interview but also during transcription of interviews in some instances became a source of distress for me. Listening to how men explained their use of violence outside the interview context often left me as the researcher with feelings of anger and sadness. A process of self-reflection was thus important in dealing with these emotions and how it impacted on me as I had to be conscious of the potential of vicarious trauma. Debriefing was a useful tool in dealing with some of the emotional challenges which I faced.

2.3.4 Data Collection

A cluster of interviews were conducted for each man. A total of 74 interviews were conducted. Each cluster included two interviews with the men in prison, each ranging between 1 to 2 hours and held two to three weeks apart. The cluster further included between 1 and 3 interviews with friends or family members of both the victim and perpetrator. These interviews with the family and friends allowed the researcher to gain further insights into the men's relationship, a different perspective on

the woman who was killed (other than that offered by the perpetrator), all which interviews with the men alone would not have provided. It is thus viewed as a cluster rather than repeat interviews. These interviews also allowed the researcher to explore the incident and its context from different perspectives. A scope of enquiry was developed and was used as a guide during the interview (Appendix 7). Using semi-structured interviews allowed the agenda to be flexible although partially directed by the researchers interview guide. Interviews were mainly conducted in an office in the social work department, with a few interviews held in the administration section of the prison.

The first interview involved an exploration of childhood which included the following areas: their family of origin, parenting during childhood, social setting in which they were raised, violence in childhood, schooling, childhood friendships, relationship with siblings as well as discipline during childhood. Data gathered in this interview guided the planning and direction for the second interview. The second interview predominantly focussed on the relationship between the man and the woman killed. Interviews were conducted, in either English or Afrikaans, the preferred language of the respondent. Consent was obtained for interviews to be tape recorded. All interviews was transcribed verbatim and translated into English.

2.3.5 Data Analysis

Opencode software was used to assist in the handling of data. Analysis was an ongoing process and commenced before the second interview. Data was analysed inductively using a grounded theory approach. Grounded theory analysis contains five essential elements:

1) The theory both emerges and is grounded in the data

2) The researcher seeks to understand social processes

3) Each piece of data is constantly compared to every other piece of data

4) Data collection procedures may be modified as the study advances and

5) The researcher analyzes data as it is collected

(Strauss & Corbin 1998)

Coding in grounded theory occurs in three phases (Charmaz 2009;Strauss & Corbin 1998).The first stage of coding is called open coding where the general phenomena of importance is identified in a relatively unstructured manner. The initial codes broadly corresponded to questions as grouped in the scope of enquiry. The researcher coded small units of data, line by line to identify patterns and concepts. Concepts were examined for similarities and differences, and relationships among them identified.

Axial coding or the second phase takes this process a step further. It has as its purpose to answer questions on the 'why' and the 'how' of phenomena under investigation. It is the process of relating codes as well as to synthesis and organise data through a mixture of inductive and deductive thinking. In axial coding, the researcher thus moves farther from the respondent's own words to begin creating a novel conceptualization of why, and the conditions under which the categories occur and relate to each other (Strauss & Corbin 1998).

In the selective coding and final integrative step of grounded theory development, the core categories are identified and the relationships among concepts are specified in order to tell a story with the aim of developing an emerging theory (Cresswell 1998). In the final phase

processes are described with the aim of presenting an integrated theoretical schema (Strauss & Corbin 1998). Although described as linear, the coding process is actually more fluid with axial codes sometimes emerging during open coding, and additional categories emerging during axial coding. As more data was added, prior interviews needed to be returned to through a constant comparative process.

My PhD supervisor (R Jewkes) and co-supervisor (N Abrahams) were both involved in coding and discussion of coding decisions. The initial broad codes and sub-codes and interpretation of results were developed under the guidance of the supervisors to assure credibility of data. Finally the paper attempts to incorporated sufficient data of adequate richness to allow the reader to determine how credible the conclusions are and that it is grounded in the data.

2.3.6 Ethical Considerations

Data was collected after ethical approval for the study was obtained from the Medical Research Council's Ethics Committee (Appendix 8) and the University of the Witwatersrand Ethics Committee (Appendix 9), in addition permission was granted by the Department of Correctional Services (Appendix 10) to conduct research in prison as well as to access to men in prison.

i. Accessing Research Participants and Informed Consent

The researchers had to take into account that the primary respondents were incarcerated men. Informed consent was of primary concern in a prison environment as care had to be

taken that the men did not feel coerced into participating in the study. Potential study participants were identified via the national female homicide study. As all potential cases had been through a court process and convicted, such information was in the public domain. Utilising the police case number, a follow-up process with the police provided us with a court record number which enabled the Department of Correctional Services to trace perpetrators. Contact was made with them via the social workers at the correctional facility. They were informed about the study by the researcher and given time to decide whether they wanted to be contacted by the researcher again. The respondents were informed that should they not want to participate there would be no negative consequences for them. Written consent was obtained from the men for interviews before the first interview (Appendix 11).

ii. Support for research participants

Support for these men was considered important, as they were asked to relive painful experiences. Prior to commencing the study in a prison, a meeting was held with the social work and psychology department at the facility. This allowed them to gain an understanding of the study and for the researcher to get their agreement to support respondents. This strategy worked well as the respondents were aware that they could make contact with a social worker, where men had never been seen by one, arrangements were made for them to be seen for counselling.

iii. Ensuring the safety of participants

The safety guidelines for doing gender based violence research with women developed by WHO were followed even though abused women themselves were not interviewed (WHO 1999). These guidelines have been used by the Gender & Health Research Unit in all the studies they have done on gender-based violence since it was written. Families and friends who required support after an interview were referred to The National Institute for Crime Prevention and the Reintegration of Offender (NICRO) for counselling and ongoing support.

iv. Confidentiality

Confidentiality of interviews were of importance in this prison population, as one had to weigh-up the safety of the researcher with their right to confidentiality. At one facility, interviews were conducted with a warden on the other side of a window, while at the second facility the warden was stationed outside the room with both not in hearing distance of the conversation. All respondents were at all times reassured that all the information they shared were confidential and would only be used for research purposes. Since the judicial process had been completed the information from the research could not be subpoenaed as evidence and used against them in court. All respondents were assured that they could refuse to answer any question and that they could stop the interview at any time.

The men were asked to identify and facilitate access to friends and family for interviews. It was initially viewed as a risk that men would be reluctant to provide details of family and friends of the deceased. This only occurred in one instance although the man initially

provided consent, he later decided he would not be happy with me having contact with the victim's family. Family and friends were mainly contacted via telephone initially to make contact, information sheets were either faxed or mailed to them, prior to setting-up the interview. Informed consent was only taken once the researcher met with the family and friends.

v. Safety and support of the researcher

Importantly the safety and mental health needs of the researcher was of primary concern. Conducting research on sensitive issues requires a system of debriefing. This mechanism was built into the study to provide the researcher with space to deal with issues of vicarious trauma. It was important for the research process that the researcher's feelings towards the perpetrator do not impact on the interview therefore the researcher had to be aware of her own feelings at all times. Conducting interviews in prison was a potential risk to the safety of the researcher. Therefore mechanisms to ensure the safety of the researcher had to be considered at each facility.

CHAPTER THREE

DISCUSSION AND CONCLUSION

This discussion highlights the main findings from the papers which form the body of work in this thesis. The findings are discussed collectively in order to present an argument that there needs to be a multidimensional approach to intimate femicide. This discussion will review the main findings from each paper and examine its relationship the other papers, as well as explore its significance. This section also discusses the limitations of the study and how these may impact on the reliability and validity of findings. I conclude by discussing the public health significance of the findings and the implications it holds for policy and practise, including key areas for future research.

3.1. Discussion

3.1.1. Rates of Intimate Femicide

The research undertaken for this thesis has shown that South Africa has an extraordinarily high rate of female homicide. We estimate that the South African rate is 24.4 per 100 000 females which is 6 times the global rate of 4.0 per 100 000 (Abrahams et al. 2009) with it far exceeding the reported female homicide rate of 1.30 per 100 000 for United States (Violence Policy Centre. 2007). Although the rate found by this study is similar, it is slightly higher than the previously reported rate of 21.0 per 100 000 females, which used vital registration data and the cause of death profiles from the urban-based National Injury Mortality Surveillance System (NIMSS) (Norman et al. 2007). It was also established that 50.3% of female murders were perpetrated by an intimate partner (Abrahams et al. 2009), which is similar to proportions reported in other studies across the world (Arbuckle et al.

1996; Heise & García-Moreno 2002; Moracco, Runyan, & Butts 2003). We further estimated that South Africa has an intimate femicide rate of 8.8 per 100 000 females 14 years and older, which is much higher than rates reported in studies from the United States (Arbuckle et al. 1996; Mercy & Saltzman 1989; Paulozzi et al. 2001; Puzone 2000; Violence Policy Center 2007), the United Kingdom (Brookman & Maguire 2004;Mouzos 2001), Australia (Mouzos 2001), Canada (Dawson, Bunge, & Balde 2009; Wilson & Daly 1993) and Israel (Landau & Rolef 2001). These studies were however not directly comparable due to methodological differences in determining cases as well as the denominators used in the calculation of rates; such as married persons. The rate for South Africa is 2.5 times higher than that reported from the North Carolina study that used the same case ascertainment methodology (Abrahams et al. 2009; Moracco, Runyan, & Butts 2003). This study estimated an intimate femicide rate of 3.5 per 100 000 females 15 years and older (Moracco, Runyan, & Butts 2003). Other than these excessive rates, a distinctive pattern in intimate femicide compared to non-intimate femicide was noted. The demographic pattern of intimate femicide cases differed from that of other female homicide victims, but was more similar to that of intimate partner violence victims found in the South African Demographic Health Survey (DHS) for 1998 (Department of Health 2002). In particular the highest rate for intimate femicide was found amongst Coloured women, 18.3 per 100 000 women 14 years and older, with the DHS also showing that Coloured women were more likely to have lifetime experience of intimate partner violence (Department of Health 2002). The age pattern for intimate femicide also showed marked similarities with intimate femicide decreasing in the older age group (≥45 years), and older women less likely to be in a current violent relationship. These findings indicate that intimate femicide, like intimate partner violence holds a greater risk for younger women and Coloured women in South Africa

(Abrahams et al. 2009). This suggests that intimate femicide is somewhat different from other homicides and can better be understood as part of the problem of intimate partner violence (Abrahams et al. 2009).

The research in paper IV shows that 19.4% of perpetrators of intimate femicide commit suicide thereafter. This appears to be at the lower end of the documented international range of 18 – 40% (Cooper & Eaves 1996;Easteal 1994; Koizol-McLain et al. 2006; Lund & Smorodinsky 2001; Morton et al. 1998), something that could well be explained by the overall high levels of interpersonal violence in South Africa. Suicide is estimated to be 11% of non-natural deaths, which is comparable to global suicide rates, and so proportionately suicide is not elevated (Burrows et al. 2003). Paper IV reports an intimate femicide-suicide rate of 1.7 per 100 000 women 14 years and older, with this rate not comparable to most homicide-suicide studies as these do not include the killing of both men and women. The only comparable rate is for North Carolina, where over a 5 year period (1988-1992) the rate initially was 0.67 per 100 000 and was observed to rise to 1.06 per 100 000 (Morton et al. 1998). Given the particularly high rates of intimate femicide established by this study it is not surprising that the intimate femicide-suicide rate should be high too.

3.1.2. **Injuries & medico-legal practises**

Paper II is the first to report on injury patterns of female homicides and the associated medico-legal practises in South Africa. An examination of injury patterns and mechanism of death of female homicide shows that the use of blunt force, especially applied to the head and face, is more likely in homicides by intimate partners. These findings are similar to those of studies on acute injury patterns of victims of intimate partner violence seen in emergency

department settings from developed countries who was also more likely to have blunt force injuries to the head and face (Perciaccante, Ochs, & Dodson 1999; Petridou et al. 2002; Sheridan & Nash 2007). However, the mechanism of death has been shown to be somewhat different in South Africa from the United States, with blunt force injuries more likely in South African intimate femicides, while firearm homicides are the leading cause of intimate femicides in the United States (Arbuckle et al. 1996; Bailey et al. 1997; Campbell et al. 2003). Gun availability and the use of guns is nonetheless a significant problem in South Africa, as 30% of intimate femicides were caused by guns with an association showing borderline significance between gun homicides and intimate femicide (p = 0.056). In addition firearm homicides were found to be the leading cause of overall female homicide, with single injuries to the head and face, as well as thorax, being the most likely location of injuries. The lethality of guns is undeniably demonstrated by the pattern of death caused by a single injury in more than two-thirds of gunshot injury femicides. The association between blunt force and intimate femicide is noteworthy as it indicates a possible difference in dynamics for South Africa. This is possibly due to how violence manifests in intimate relationships in South Africa, with it used as a tactic to secure control and respect (Coovadia et al. 2009; Wood & Jewkes 2001). Blunt force as a mechanism of death also indicates the level of aggression and violence used. The three province study on intimate partner violence shows that a relatively high proportion of women in South Africa report injuries and a large number of these women seek medical assistance suggesting that men are possibly very brutal in their violence towards intimate partners(Jewkes et al. 2000a). These levels of aggression and violence appears to be exacerbated by harmful alcohol use by both men and women, as shown in paper three, as intoxication impair judgement and conflict can escalate

when both partners are under the influence of alcohol. With guns there is possibly more planning which is thus a feature if intimate femicide-suicide.

The weaknesses in medico-legal practises were highlighted in paper II. This study found that only 70% of all female murders had a full autopsy performed. During data collection it was also established that in some instances the body is prepared by the mortuary assistant and only viewed by the pathologist or district surgeon. This has important implications for the accuracy of the post-mortem report and in particular the correct description of injuries and wounds. The post-mortem report is an important part of the medico-legal evidence as it is used in by the prosecution to lead the medical evidence in court. This paper also included an assessment of the standard of post-mortem reports which revealed the poor documentation of injuries, in particular the description of anatomic location of injuries was often imprecise, with poor specification of wound dimensions. These findings indicate that autopsy practises require attention, as performing a full autopsy should be standard practise in any medico-legal investigation (Vellema 2006). Furthermore 18.6% of cases were closed as undetected, since the police investigation did not yield a suspect. The forensic pathologist has an important role in the criminal investigation as the autopsy report should take into account both the external and internal examination, the toxicological results, as well as evidentiary material for use in the criminal investigation and help solve the murder (Nadesan 1997; Vellema 2006). These practises therefore hold important implications for the criminal investigation as the accuracy of the post mortem report and correct interpretation of autopsy findings are all crucial in the criminal investigation as it can lead to more suspects being prosecuted and can result in an increase in convictions.

3.1.3 Alcohol use

Alcohol and its relationship with intimate femicide were also highlighted by this thesis. Risk factor studies in South Africa have shown that alcohol abuse increases the risk for violence in an intimate relationship (Abrahams et al. 2006; Jewkes, Levin, & Penn-Kekana 2002). Paper III has revealed that many victims of female murder have consumed substantial amounts of alcohol in the hours before their murder, and although we lack information on the perpetrator's BAC, there seems to have been considerable overlap between victim and perpetrator use of alcohol. Women who were killed by intimate partners were found to have a very high median BAC (0.20g/100 ml) at the time of their death, as two thirds of women who were killed by an intimate partners had an elevated BAC (≥ 0.05) at the time of their death. This pattern of alcohol use appears to differ from that of the United States where women who are killed by an intimate partner are more likely to be sober at the time of their killing (Sharps et al. 2001). The alcohol pattern in the United States fits the pattern for South African gun homicide victims in paper IV, which showed that 82.1 % of women who were killed by guns were sober at the time of their killing. This could be linked to the massive abuse of alcohol in South Arica, with the country having the highest alcohol consumption in the world per individual who drinks (Seedat et al. 2009). High levels of alcohol abuse combined with traumatic childhood experiences, structural disadvantages due to apartheid, could all exacerbate conflicts within intimate relationship. Furthermore unemployed women who are killed by an intimate partner were found to have a higher median blood alcohol level. Discussions with community based organisations in the region have pointed to the relationship between very heavy communal drinking and involvement in fights as a result of both partners being very drunk and lacking the necessary social skill to resolve conflicts by other means. The female partner's drinking can also lead to an increase

in conflict in the relationship, and the male partner can use her drinking as an excuse to be violent (Jewkes, Levin, & Penn-Kekana 2002). In addition her drinking increases her vulnerability, as alcohol abuse generally decreases the person's ability to cope and therefore she is not able to leave the relationship (Seedat et al. 2009). She is therefore unable to defend herself thus an assault can become lethal.

This thesis has also highlighted the excessive levels of public intoxication; it was shown that women are more likely to be killed over weekends and in public spaces with an elevated BAC. South Africa has an overall pattern of very high alcohol consumption (Parry 2005), as well as generally high levels of interpersonal violence. These two problems intersect to exacerbate levels of intimate partner violence experienced in South Africa. Patterns of alcohol use are based on social, cultural and gendered relations with a society (Redpath et al. 2008). Heavy drinking is socially acceptable for both men and women and is recreational, as there are few alternatives for recreation in most impoverished communities (Morojele et al. 2005). Heavy social drinking poses a major public health risk in South Africa, with the South African DHS defining heavy drinking as having five or more drinks for men and three or more for women per day (Parry et al. 2005). No comprehensive strategy exists to address risky alcohol consumption in South Africa, current policy is embedded in the Department of Welfare's National Drug Master Plan of 2000 which addresses substance abuse as an overarching problem but it lacks the necessary funding for effective implementation (Seedat et al. 2009). The World Health Assembly has recently adopted a resolution aimed at developing a global strategy to reduce harmful use of alcohol (World Health Assembly 2008). South Africa has to develop initiatives that are in line with this global strategy. Key to prevention is not just regulating the selling to alcohol, to whom and when, but rather

shifting norms around patterns of drinking in order for both men and women to understand the risks and consequences of risky alcohol use.

3.1.4. Firearms and their relationship with intimate femicide

The role of firearms in intimate homicides has been clearly demonstrated in multiple ways by this study. Paper II shows that gunshot injury was the leading cause of homicidal deaths for females with a female firearm homicide rate of 7.5/100 000 females 14 years and older , which is 5 times the only comparable rate of 1.5/ 100 000 women in the United States (Hemenway, Shinoda-Tagawa, & Miller 2002). Although blunt force injuries were shown to be associated with intimate homicides, gun homicides were nearly as common among intimates as non-intimates points to the importance of firearms in intimate femicide. This gun homicide pattern in females is similar to the overall pattern of homicide in South Africa with firearms playing a leading role in homicide (Seedat et al. 2009). Endemic levels of violent crime as well as high levels of firearm homicides in South Africa have been linked to the availability of illegal guns (Lamb 2008).

Paper IV shows that guns played an important role in intimate femicide-suicide, as these were found to be strongly associated with the perpetrator owning a legal gun, with more than two-thirds of perpetrators doing so. The population attributable fraction shows that 91.5% of these could have been averted if the perpetrator did not own a legal gun. Gun ownership reform in South Africa has had a strong emphasis on reducing the numbers of illegal guns as these have been associated with violent crime, including homicide. This study, however, highlights the need to focus on restricting legal gun ownership given its

relationship with intimate killings and the public health risk gun ownership thus pose in intimate relationships.

Evidence from the United States suggests that restricting gun access for male abusers who have a restraining order decreases the incidence of intimate femicide (Vigdor & Mercy 2006). The Firearms Control Act no 60 of 2000 (Republic of South Africa 2000) makes provision for such restrictions through the requirement of a competency certificate, as well as granting the police and Courts the power to declare a person "unfit" to possess a firearm. The policy framework thus exists for restricting gun access, which is the first step in reducing such murders and requires vigorous enforcement. Gun ownership and the use of guns is a symbol of male power across the cultural spectrum in South Africa (Cock 2001). Cock (2001) argues that gun ownership is rooted in dominant notions of masculinity across the racially defined masculinities in South Africa thus with gun ownership, we have an increased risk of women being killed in the home as conflict between intimates has a greater potential of becoming lethal in the presence of a gun.

3.1.5. Masculinity

Reductions in levels of gun violence as well as intimate partner violence in order to prevent intimate femicide, requires us to challenge current dominant constructions of what it means to be a man. Dominant notions of masculinity in South Africa are rooted in a patriarchal gender order with men having power over women and they legitimise men's use of violence against female intimate partners under the pretext of discipline (Coovadia et al. 2009; Wood & Jewkes 2001). The declining rates of intimate femicide in Canada and the United States have been shown to be associated with an increase in gender equity (Dawson, Bunge, &

Balde 2009; Dugan, Nagin, & Rosenfeld 1999; Dugan, Rosenfeld, & Nagin 2003), building gender equity is thus a key strategy in preventing and reducing this form of violence.

Paper V shows that the shaping of male identity or masculinity is an active process with childhood experiences such as parenting practises and social context influencing the formation of violent masculinities. The qualitative study with men has also shown us that the social context in which most men were raised has permitted fathers to be completely absent or uninvolved in their care, with mothers taking on the primary parenting role. Neglectful and violent parenting practises at the hands of mothers and fathers combined with violent social settings in which most of these men were raised are important factors influencing the formation of violent masculinities. The experiences of poor parenting practices and abuse during childhood made these men feel powerless, inferior and unloved thus turning to influences outside the home like gangs and crime as means to gain respect, power and love.

This paper shows that social context these men were raised in enabled them to take on discourses of violent masculinity which is highlighted in their individual accounts, this notion as a pathway to violence is also supported by the work of Frosh and colleagues (2003). This combined with traumatic childhood experiences, left these men psychologically vulnerable. Understanding the underlying psychological processes is difficult, as no formal psychological assessment of these men were conducted. Nevertheless for these men to continue to cope emotionally it is plausible that they developed psychological strategies to deal with reality and maintain a self image. From a social psychology perspective, it is possible that they experience cognitive dissonance when violent in an intimate relationship

and it is this dissonance that allows them to suppress their emotions and rationalise their violent behaviour in order to protect their self image (Baron & Byrne 2004) Alternatively, drawing on a psychoanalytic discourse, it is possible for these men to develop an unconscious ego defence mechanism in order to cope with their psychological vulnerabilities. It is plausible that a defence such as dissociation is used to avoid feelings of emotional distress in order to cope psychologically with their acts of violence. While the more pathological defence mechanism of splitting is also possible as most of these men fail to integrate good and bad images of both the self and others, with splitting then allowing violent acts towards someone they love (Cramer 1991). Developing a definitive theory on the psychological vulnerabilities of men who kill intimate partners is a complex area and requires further research.

Importantly, in a study with men who has taken on caring roles in South Africa, it was found that strong positive parental attention, often from social parents not just biological are key in taking on caring roles (Morrell & Jewkes 2009). This relationship between parenting experiences and shaping of identity is thus a complex area and requires further exploration. To change violent practices of men, Dunkle & Jewkes (2007) propose that it requires gender transformative work with men to shift underlying gender norms rooted in practises that promote male dominance and control.

A World Health Organisation review of the effectiveness of programmes and interventions to build gender equity (Barker, Ricardo, & Nascimento 2007) has shown the efficacy of working with men and boys to promote gender equity. In South Africa, an evaluation of Stepping Stones as a gender transformative programme, has shown that over a 2 year

follow-up there was a sustained reduction in young men's perpetration of violence against an intimate partner (Jewkes et al. 2008). The challenge facing us in South Africa is to promote alternate ideals of masculinity, lessons from Scandinavian countries has shown us that this change is possible if grounded in policy changes (Morrell & Jewkes 2009).

The above discussion highlights the notably high levels of intimate femicide in South Africa and the need to address the prevention of such killings. A range of factors has been shown to increase the risk for intimate femicide. Prevention efforts in South Africa have to take these factors into account in developing an effective strategy to prevent these murders. The following section thus discusses recommendations based on the findings of this thesis.

3.2 Recommendations to prevent intimate femicide in South Africa

This thesis has shown that intimate femicide is a complex phenomenon with a web of associated and mediating factors which all contribute to these excessive levels of intimate femicide prevailing in South African. Preventing such murders from occurring thus requires a multi-dimensional response that takes into account this complexity.

3.2.1.Building Gender Equity

At a primary prevention level a key strategy to prevent intimate killings is building gender equity by working with both men and women. Improving the status of women is an important component as this will enable women to feel more valued and enhance perceptions of self worth, and start to level the power imbalance between men and women. Strategies to reduce men's use of violence needs to evidence-based, therefore there should be an emphasis on integrating best practice models into programmes. Evidence has shown

that gender transformative programmes, such as Stepping Stones, reduce men's violence in intimate relationships (Jewkes et al. 2008), and small loans combined with participatory action learning was effective in reducing women's experiences of intimate partner violence (Pronyk et al. 20060). Government thus needs to take the lead by providing the necessary resources to promote and rollout such promising interventions to prevent violence in intimate relationships.

3.2.2. Strengthening Policy Responses

The government in 2007 launched an intersectoral prevention strategy, the 365 Day National Action Plan to end violence against women however there is limited evidence of its implementation (Seedat et al. 2009). Furthermore there is a need to strengthen existing policies to offer women increased protection from intimate partner violence which is broader than specific legislation on domestic violence. For example the current alcohol policies is limited in its focus, policy reform should centre on primary prevention, with the aim of shifting norms around harmful alcohol use in both men and women in order to reduce its effects. A comprehensive approach should take into account both societal and individual factors (World Health Assembly 2008). Addressing harmful drinking requires innovative strategies which should be focussing on creating alternate norms, raising the general awareness and educating general population on the risks of excessive with the aim of changing the culture if drinking as well regulating illegal liquor outlets. Civil society has an important role to play, not only to lobby policy makers, but to also monitor policy development and its implementation. In addition, although the Firearm Arms Control Act of 2000 (RSA 2000) is considered to be comprehensive, its implementation requires active monitoring. It is also important that further restrictions on regulating the use of guns is

prioritised, in particular for those working in the security industry like police officers where service weapons are used in such killings.

3.2.3. Developing a Health Sector Response

Evidence from the United States found that 40% of women access health care facilities the year prior to their killing (Sharps et al. 2001). Policies and protocols within the heath sector have predominantly focused on sexual assault, with a response to intimate partner violence being rather fragmented. This lack of a health sector response is thus missing an important opportunity to prevent intimate partner violence from escalating into a murder. Furthermore, the Domestic Violence Act No116 (RSA 1998) does not provide the health sector with a clear role in the management of domestic violence cases, limiting its effectiveness. Evidence from developed countries as well as Latin America suggest that screening in health settings and managing identified cases appropriately has the potential of protecting women from further abuse and thus preventing intimate femicide (Campbell et al. 2007; Morrison, Ellsberg, & Bott 2004).

3.2.4. Improving services for intimate partner violence

Improving services for abused women is still a critical part in preventing intimate femicides from occurring. In the United States the declining rates of intimate femicide has been associated with an improvement in service provision, with virtually every community having access to domestic violence hotlines and emergency shelters for women and their children, as well as survivor and perpetrator intervention programmes (Campbell et al. 2007). The availability of such community based resources thus enables the women to access services and secure safety before intimate partner violence becomes lethal.

3.2.5. Enhancing parenting practises

Childhood experiences such as neglectful and violent parenting practises influence the formation of violent masculinities. In addition, structural environmental factors like poverty influenced parent's ability to be emotionally and physically available. Changing parenting practices and strengthening families as a prevention strategy appears to be central in mediating the effects adverse childhood experiences. The Children's Act No 38 (Republic of South Africa 2005) as well as the Children's Amendment Bill of 2007 provides a framework aimed at strengthening families and communities to care for and protect children. It is within this framework that strategies to strengthen parenting practises needs to be framed.

This study has been very important, as it addressed a neglected area of research in South Africa and other developing setting and provided us with valuable new knowledge. Nevertheless all studies have its strengths and limitations and should be considered in our interpretation of data and how it is used. The following section will be highlighting the strengths and limitations of both the quantitative and qualitative studies.

3.3. Study Strengths and Limitations

3.3.1. Study One

The strength of the study lies in its design. The stratification and clustering of mortuaries made a study of this nature possible without this it would have too large and costly. The design also allowed for the calculation of national estimates of female homicide, intimate femicide and intimate femicide-suicide with fair precision. The design was novel as it gathered multiple sources of data, from mortuaries, as well as the police, to enhance the

reliability of estimates. It is this design that has attracted interest as it can be replicated in less developed settings where routine crime data is not recorded systematically. Globally there has been a call for strengthening our understanding of the nature and prevalence of femicide by generating comparable data across countries (Widyono 2009). Understanding the nature of female homicide in a country is thus an important first step, as cultural context and the status of women in country influence the interpretation of findings.

i. Reliability

A single researcher was responsible for data collection which enhanced the consistency of the data collection. The use of a standardised data collection tool added to the uniformity and reliability of the data collected. Furthermore, the research team's forensic pathologist was responsible for the data extraction and assessment of the pathology reports. As there was only one person making this assessment it enhanced the consistency and reliability of this assessment across the data set. The forensic pathologist also applied standardised measures of assessing the quality of the post mortem quality in an attempt to reduce bias of the assessment and enhance reliability of the assessment.

ii. Missing Data and Bias

Although access was obtained to all mortuaries, full case data was only obtained in 86.7% of cases, as police data was needed to complete case data collection. After an exhaustive search, using area commissioners, no police case could be traced in 6.9% of cases, indicating flaws in the medico-legal process. The majority of these cases were either women who were unknown at the time of their death, or did not have the social network where someone inquired about their disappearance. Furthermore, in a substantial proportion of cases

(18.6%) the police had no suspect, not only did this reflect poor police investigation but in the majority of these cases were murders of African women. This appears to be rooted in our past with police in some areas still poorly resourced and understaffed (Schönteich 2000), while attitudes of male police officers reflect the gender hierarchy inherent in South Africa, as well as the under-valuing of African women's lives. . Whether there is an inherent bias in this missing data is difficult to determine, however it is unlikely that there would be bias towards a specific type of murder in these cases. In 6.4% of cases identified police dockets were missing, these missing dockets could pose a potential bias as bribes to "make" dockets disappear are common in South Africa due to corruption or sympathy with perpetrators of intimate partner violence (Altbeker 2005). Furthermore it is also possible that there was an incomplete ascertainment of deaths, due to bodies not having been discovered. These limitations would suggest that there is a possible underestimation in the rate of intimate femicide, as well as possibly intimate femicide-suicide in this study (Abrahams et al. 2009).

Police interviews were used for case identification. The study showed that police did not routinely enquire about previous history of intimate partner violence, and interviews with male police officers revealed that they at times adopted attitudes blaming the victims. We also sometimes relied on a police officer's memory of a case and what was documented in the police docket. Based in my experience of conducting police docket reviews, it was found that case dockets were often incomplete and information went missing between the police and court. It is therefore possible that the accuracy of data gathered from investigating officers could be influenced by recall bias and not entirely reliable. Furthermore a police detective on average has 57 category A crime (i.e.murder, rape & robbery) cases on their

case load (Redpath 2002), indicating just how difficult it would be to rely on memory for details on cases.

iii. Generalisability

Paper III presents an analysis of alcohol data which was only complete for the Western Cape. This region is known for its high alcohol consumption due to the legacy of the "dop system" and the residual pattern of heavy drinking that has remained in the rural framing communities. The findings from this paper is therefore not directly generalizable to South Africa as a whole, but provide important insights into emerging patterns of alcohol consumption and female homicide.

iv. Cross-sectional Design

Due to the cross sectional design of the study we are unable to draw causal inferences based on epidemiological criteria. Although we show an association between certain variables and the outcome, intimate femicide, the temporality of such associations are difficult to determine. While it is reasonable to assume that a women's use of alcohol can lead to conflict and lethal violence, her use of alcohol might also be as a result of the intimate partner violence she has been experiencing over time, thus we cannot establish timing of risk factors. However the plausibility of these associations is also based on previous risk factors studies on intimate partner violence which has shown some consistency.

3.3.2. Study Two

The strength of the qualitative study is in the cluster of interviews for each man, as multiple sources of information allowed the collection of rich data about each case. Furthermore care was taken in the how data was collected in the interview. The researcher adopted a strategy of critical engagement, which recognised the importance of building rapport to acquire valid data and also required a constant critical evaluation of the self, the men being interviewed and the interview data acquired. Active listening was used as a tool to build rapport and to gain interesting and useful data (Hearn 1998), presenting oneself as interested in their "story" and by using probing to gather further information. The critical engagement allowed me to be aware of my responses to their accounts and to be aware of possible collusion. Nevertheless the accounts of the men in the qualitative study present their own reality.

An important limitation of the study is embedded in the self selection of men to participate in the study. The men were recruited into the study after they volunteered to participate, therefore men who did not volunteer might have provided different insights into this phenomenon. The fact that these men volunteered suggests that they had a need to talk to someone about the event, although only two men did not agree to participate in the study, they might have had different experiences.

The researcher was aware that being a female as well as the research setting (prison) influenced the interview process and how respondents represented themselves and considered to be a threat to obtaining credible data. In the design of the study it was acknowledged that perceived and narrated experiences might differ from these men's

actual experiences. To overcome this possible threat to the credibility of data, interviews with relatives and friends enabled many of the circumstances described by the men to be confirmed by other family members.

The reliability and validity of the findings of the qualitative study was firstly ensured through the recording of all interviews and verbatim transcriptions. Reliability was further ensured through the rigour used in the data analysis process, as the supervisors were involved in coding and checked for comparability. Plausibility of the interpretation of findings were hoped to be achieved by keeping the analysis close to the data, and by showing how interpretations were produced.

3.3. Implications for Public Health

This thesis has shown that intimate femicide is a huge public health problem that requires urgent attention. Importantly, this study has demonstrated that intimate femicide is not an extension of female homicide, as conceptualised in some previous work, but that it is a consequence of intimate partner violence and thus require a different response. This holds important implications how intimate femicide is addressed within the South African context. This would suggest that how such murders are investigated should be reconsidered as it cannot be approached from the same perspective as a "homicide". With the majority of police officers still male in South Africa, this also has implications for the criminal investigation of intimate femicide as there can be collusion with perpetrators. Police training is thus an important component in ensuring justice for women and successful

criminal investigation outcomes. This can send a message out to men that such violent acts will not be tolerated.

The study also showed that intimate femicide is a complex phenomenon with a number of associated factors, such a child rearing, gun ownership and drinking patterns, contribute to the excessive levels of intimate femicide. It has been shown that excessive alcohol use increases a women's risk, and gun ownership increases the man's risk committing suicide after killing an intimate partner. This has important public health implications for policy development and implementation.

A comprehensive policy on reducing harmful use of alcohol is imperative in South Africa as the social costs of alcohol use is estimated to be R9 billion per year (Seedat et al. 2009). Government's lack of a co-ordinated response to reduce risky drinking and can take lessons from the success they have had with smoking policy in South Africa. Similarly South Africa has a Firearm Control Policy which restricts gun access, but no further policy reform on guns have been promoted by government. There appears to be a lack of political will to revamp and enforce current policies. It therefore requires a public health response that vigorously lobby government to revised policies and to monitor government with regards to adequate implementation of polices.

Intimate femicide has been shown to be a consequence of social context combined with the psychological vulnerabilities of the male partner, as well as male identity and dominant notions of masculinity key which are all key factors in such killings. South Africa has a policy framework in place that promotes gender equality, which is the first step in creating a more

gender equitable society. Working towards this does not mean an exclusive focus on men and masculinity, but that women should be part of this dialogue. Promoting alternate, masculinity and femininity is the challenge for South Africa but should be the cornerstone of prevention approaches. Care should be taken that in our efforts to include men in prevention that we do not lose sight of women.

This thesis has advanced our knowledge on intimate femicide in South Africa by highlighting our excessive rates as well as the complex interrelationship of factors which are associated with this phenomenon. Importantly the results have also revealed interesting areas which require further research.

3.4. A Future Research Agenda

This study has shown that our pattern of intimate femicide differs from that of other countries where intimate partner violence is equally prevalent. It is important that we explore this further as there appear to be factors in the South African social context that facilitates violence in intimate relationships to escalate and become lethal. Understanding these factors will allow us to develop better prevention strategies to reduce the incidence of such killings.

Increasing gender equity within relationships has been shown to be an important strategy to reduce violence within intimate relationship. Our models of what constitutes gender equitable relationships are based on studies from the North and require further investigation in the South African setting. We need to develop an understanding of what shifts in masculinity and femininity are required to produce increased equity within

relationships. In addition, it is important that we document the trend for intimate partner violence in South Africa. Given that intimate partner violence is rooted in gender inequality in relationships it is an important marker to assess whether South Africa as a society is becoming more gender equitable.

The relationship between parenting practises and the shaping of identity is complex and requires further exploration. Importantly the impact of harsh parenting practises and its relationship to men taking on violent forms needs to be better understood, as this is imperative to reduce violent male practise. Thus further research to explore this link should be prioritised to inform prevention and intervention strategies in order to promote the development of less violent forms of masculinities.

Risky alcohol use is a feature of South African society which affects both men and women. There is a complex reciprocal relationship embedded in harmful alcohol which negatively influences the use of violence within intimate relationships. Women's use of alcohol and her associated vulnerabilities is an area which is underexplored in South Africa. We need to expand research to develop a better understanding of how women's risky drinking impacts on the risk for victimisation.

3.5.Conclusion

This thesis has shown that South Africa has excessive rates of intimate femicide which poses an immense public health burden. The complexity of this problem has been highlighted by this study as it has shown that such murders are associated with a "web" of interrelated factors. Of significance, this thesis has demonstrated that intimate partner killings has a

gender dimension and is as a consequence of intimate partner violence rather than the general levels of violence and homicide prevalent in South Africa. It is therefore imperative that effective prevention strategies take into account not only the associated factors like, gun ownership, risky alcohol consumption and parenting practises but requires working towards gender equitable relationships between men and women in South Africa. The constitution of South Africa provides the policy framework for a gender equitable society, however transforming notions of masculinity and femininity is the challenge facing prevention of such killings in South Africa.

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