Stepping Stones and Creating Futures Intervention Trial

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Executive summary

Over 30% of women globally have experienced physical and or sexual intimate partner violence (IPV) in their lifetime [1]. IPV is in the top 20 of the global burden of disease, with women who experience IPV having increased rates of depression, suicidality and harmful alcohol use [1]. Studies show that South Africa has particularly high rates of IPV [2]. Reducing the perpetration and experience of IPV is a major health priority.

AIM: to determine whether the combined Stepping Stones and Creating Futures interventions are effective in enabling women in informal settlements to reduce their exposure to intimate partner violence (IPV) and men in informal settlements to reduce their perpetration of IPV, including controlling behaviours.

METHODS:

Design: A randomised controlled trial with two arms

i) Stepping Stones and Creating Futures
ii) Control arm (Cash incentive for study participation and delayed intervention)

Interventions: There are two interventions which will be delivered sequentially:

i) Stepping Stones which consists of 10 sessions of about 3 hours duration. This is a participatory intervention which is delivered in the main to single sex groups of about 20 people. It seeks to strengthen relationships and to transform views on gender and in the process impact on exposure to, or participation in, gender-based violence and HIV risk. These cover gender and peer influences our actions; sex and love; conception and contraception; STIs and HIV; safer sex and condoms; GBV; motivations for behaviour (including influences of alcohol and poverty); and communication skills.

ii) Creating Futures is a facilitated group intervention covering eleven, three-hour sessions in single-sex groups of approximately twenty people. The key sessions cover: my life and the resources I have used in my life and livelihood, setting medium term livelihood goals and the need for assets for livelihoods and coping with crises; social resources for livelihoods (trust and community participation); education and learning including past experiences and how to build on these; getting and keeping jobs including work expectations and how ones on own behaviours may impede or increase our ability to get a job and to keep it, appropriate work opportunities and increase owns own ability to market ones skills and apply for work and overcome challenges in job seeking and maintaining a job; income generating activities and how to identify viable business opportunities, the resources necessary to respond to such opportunities, basic business principles and business risks; saving and coping with shocks including spending patterns and strategies for saving, and causes and consequences of getting into debt and ways of overcoming debt.

Setting: Informal settlements in and around EThekwini Municipality (Durban)

Sample size: 1320 adults (40 per cluster – 20 male and 20 female) will be recruited in 34 clusters for the study. In each cluster will be based in an informal settlement.

Integrated qualitative research study: A multi-method qualitative evaluation of the intervention will take place, comprising of 40 repeat in-depth interviews (20 women, 20

men), participant observation in two clusters with the same interviewees and for women (n=10), PhotoVoice workshops.

Integrated costing and process evaluation: An integrated costing and process evaluation will be conducted to understand: i) the cost effectiveness of the intervention ii) challenges of delivery through a review of financial records (retrospective and prospective) and shadowing and observation of facilitators (between 4 and 8 clusters) over the course of the delivery of the intervention.

Instrument: standard questionnaires will be used. Data collection will use cell phones and will be self-administered. Data will be collected from the participants at baseline, 12m and 24m post intervention.

Qualitative instruments will be standard semi-structured questionnaires implemented by trained field researchers. Data will be collected from the same participants at baseline through two interviews, 6m, 12m and 18m post intervention.

Observation guides will shape data collection for participant observation.

PhotoVoice research will be guided by a PhotoVoice tool – this tool sets out series of four workshops spread out over 18months for women to participate in. The PhotoVoice tool sets out the workshop schedule, including participants being trained on the use of cameras and the ethics of photography before being asked to take photos to illustrate particular themes. The PhotoVoice tool, also sets out subsequent discussion of the photos will be shaped by participants and recorded for analysis.

Fieldworkers will be trained in ethnographic techniques and approaches to data collection, including taking notes to observe the delivery of the intervention and time-motion data tools.

Costing instruments have been developed to extract financial information on the costs of developing and delivering the intervention. These include standard semi-structured interviews, excel spreadsheets (for extraction of financial records).

Content: social and demographic characteristics and circumstances, personal gender attitudes and social norms, sexual behaviour (partner numbers, condom use at last sex, partner type at last sex (main or casual) transactional sex), mental health (depression, suicidality), experience of gender based violence (victimisation and perpetration), pregnancy, livelihood strengthening activities, engagement with crime.

Data analysis: The data will be analysed by intention to treat. IPV incidence will be compared between arms in the study. The primary analysis will be carried out by fitting a Poisson regression model, which will include terms for age of participant, cluster, baseline prevalence of IPV (for males or females) and treatment (arm). Other quantitative variables will be analysed with change from baseline compared between arms using GLMMs.

Qualitative: The data will be analysed using thematic network analysis. Coding will take place focused on the key questions to be answered in the study with separate analysis for women and men.

Integrated process evaluation: An integrated process evaluation will be conducted to explore how facilitators delivering the intervention to so. Ethnographic and qualitative methods will be used.

Costing analysis: The costing data will be analysed using a provider and client perspective using incremental cost-effectiveness will be calculated using the primary outcome, with costs set at 2017 rates.

Project management: The intervention is funded through the What Works to Prevent Violence Global Programme. Access to communities, recruitment of participants for the research and intervention delivery is the responsibility of Project Empower. The research is a project of HEARD at the University of KwaZulu Natal, with collaborators from the Medical Research Council. The study will be conducted over 3 years with recruitment commencing soon after ethics approval. The research will be conducted over 24 months and there will be 6 months for data analysis and writing up the findings and dissemination, and 6 months for intervention scale up if the findings are positive.

OUTCOME: This research will generate knowledge on the efficacy of an intervention to prevent IPV among an extremely vulnerable and disadvantaged sector of South African society. The study will extend knowledge globally of interventions to prevention of gender-based violence.

INTENDED FEEDBACK OF THE STUDY: The findings will be published in peer review journal articles, presented at international and local conferences and shared at a workshop with stakeholders interested in economic empowerment especially of vulnerable youth. If the study is successful we will endeavour to scale up the intervention over a year through other NGOs working in KwaZulu Natal with funding already allocated to achieve this. The What Works to Prevent Violence Global Programme is developing a dissemination strategy to give the highest possible profile to the findings of evaluation research funded through the programme and this study's findings will be disseminated through these avenues.

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1.0 Introduction

Intimate partner violence is highly prevalent in South Africa and immensely destructive. Violence and injuries are the second leading cause of death and lost disability-adjusted life years in the country[3]. Population-based estimates from 2010, show a lifetime prevalence in adult women of physical intimate partner violence (IPV) victimisation of 33% and past-year prevalence of 13%[4]. Studies with men have shown that more than 40% of men disclose having been physically violent to a partner [4, 5]. A quarter of women have been raped, and between 28-37% of men disclose rape perpetration in surveys [4, 6].

Urban informal settlements, globally and in South Africa, are rapidly expanding [7]. Data shows that urban informal settlements are spaces with particularly high prevalence of major health problems, including HIV and sexually transmitted infections (STIs) and gender-based violence (GBV), which particularly affect young people [7-10]. UNAIDS estimates that 28% of people living with HIV/AIDS in southern and eastern Africa live in 14 cities in the region (approximately 15% of the global epidemic) and in South Africa the HIV prevalence in informal settlements is twice that of people in formal housing [11, 12]. Our own data suggests that rates of IPV-incidence within young people (18-30) in urban informal settlements is between 3-5 times more than national estimates [13].

A range of different theories have been put forward to explain why urban informal settlements are particular spaces of risk. A substantial body of work has linked the high levels of poverty and material inequality found in urban informal settlements to HIV and IPV risk [14, 15]. Others also emphasise the high levels of mobility and weak social relationships that exist in urban informal settlements, undermining social forms of power that have a tendency to constrain certain behaviours [16]. Another arguments suggests how weak service delivery, informal housing and a general sense of lack of structure and support, undermine people's sense of wellbeing, contributing in indirect ways to people's poorer health [17]. A cross-cutting theme of all this work is the ways in which gender inequalities, particularly in the contexts of poverty, are pronounced and place women in economically and socially dependent relationships with men, and thus at higher risk of experiencing violence and HIV-vulnerability [14, 18]; while for men it is argued that their experience of marginalisation from the economy limits them from achieving respectability and a sense of identity through providing for households. In turn they seek other forms of identity and respect, namely through dominance over women sexually and physically [14, 19, 20].

Despite the significant health challenges that are evident in urban informal settlements, few interventions have been successfully evaluated that show impacts on reducing IPV in such spaces across the region [21]. This has been recognised by the South African National AIDS Council (SANAC), who have prioritised responding to HIV within these spaces with a particular focus on young women. As such there remains an urgent need for interventions that are deliverable in the challenging contexts of urban informal settlements that can develop an evidence base on reducing IPV perpetration and experience and HIV-risk behaviours.

The Gender & Health Research Unit (GHRU), HEARD and Project Empower (PE) have been developing, implementing and evaluating IPV prevention interventions for over a decade. GHRU with its evaluation of Stepping Stones used with youth outside school, resulted in the first evidence of effectiveness of a rigorously evaluated intervention to reduce IPV perpetration from a developing country [22]. For over 13 years PE have been implementing participatory interventions in urban informal settlements to reduce HIV-risk and IPV.

Collectively the team have for the past four years been developing and piloting a participatory intervention called Stepping Stones and Creating Futures for implementation in urban informal settlements, through transforming gender relationships and strengthening livelihoods for women and men.

This proposal outlines research on an ambitious new study that seeks to evaluate a multi-faceted intervention to prevent IPV delivered to young men and women living in informal settlements, building on promising pilot data.

2.0 The objective

The objective of the study is to determine whether the combined Stepping Stones and Creating Futures interventions are effective in enabling women in informal settlements to reduce their exposure to intimate partner violence (IPV) and men in informal settlements to reduce their perpetration of IPV.

3.0 Background

3.1 Theoretical framing of the research

This project blends a number of theoretical perspectives in the theory of change which underpins the development of the intervention. These theories operate at different levels. In understanding IPV causation, we draw on the theoretical model that was presented in Jewkes [23] which posits that IPV is a product of both patriarchy and a culture of violence. Both are necessary in order to give rise to situations in which women experience abuse in intimate relationships and both need to be tackled as part of IPV prevention. Patriarchy is manifested in distinct gender roles and hierarchy, male sexual entitlement, the low social value and power of women and expectations of male control of women. Expressions and manifestations of patriarch include women's lack of power in gender relations, low levels of education and economic power, and lack of family and social support for women in relations with men. Limited education and economic opportunities for men generates perceptions of insecurity of male identity, which lead to an accentuated need to express masculinity in terms of control of women [24].

In South Africa the culture of violence is a product of the country's violent past [2, 18]. The history of apartheid, State repression, forced impoverishment of the country's Black majority and context of resistance has led to a normalisation of the use of violence to gain and wield power. Violence is common in all areas of life, from community violence, to homes where witnessing parental IPV is an every-day event, to schools where corporal punishment persists even though it is illegal.

In order to understand how particular understandings of masculinity legitimate unequal and often violent relationships with women we use Raewyn Connell's theory [25] of gender and power and specifically her concept of hegemonic masculinity (see also [26-28]). In this context, masculinity is understood as a configuration of male practice, constructed to give expression and legitimacy to patriarchy, but also recognised as multiple, dynamic and fluid. Connell argues for the existence in a particular setting of a hegemonic masculinity, which is a cultural ideal of manhood that gains its legitimacy from acceptance that is shared between those who embody and benefit from the ideal and those subordinated through it[25]. This legitimacy is not inherently based on the use of violence, but rather on a cultural ideal that it embodies the notion of how to be a 'good' or 'successful' man. Writing about South African

youth masculinity, authors have described how young men's inabilities to secure 'success' through earning money and providing for a household, have led them to develop alternative visions of success, premised around acquiring and keeping female partners. Thus, a central construction of successful manhood includes an implicit dominance and control of women, providing a basis for the use of violent behaviour to pursue and demonstrate manhood [24, 26]. This configuration of masculinity underpins the high levels of violence against women and resulted in, for example, 42% of men disclosing perpetration of intimate partner violence and 28% disclosing rape [6, 29].

This understanding of gender recognises that women are actively involved in shaping the contours of patriarchy and its expressions, and that they have an important role in the reproduction of cultural models of gender identities. This is done in heterosexual relationships through acquiescence, or resistance, to prevailing gendered power relations. It is also done at multiple other levels for example through girls influencing the femininities of their peers in replication of ideas about how to be a 'good' girl/woman and stigmatising (or supporting) alternative constructions of femininity. In the same way boys apply pressurise their peers to supports particular constructions of masculinity over others. Gender identities are also reproduced in all other important social spaces, and critically in the home, through very similar mechanisms, but which extend from very early in a child's life. Parents play a key role in this process. Again, the wider contextual factors of poverty and lack of economic security further entrench women's social dependence on men, through their economic dependence [30]. In this way we embrace a theoretical perspective on gender relations which extends considerably beyond the idea that women are just on the receiving end of patriarchal power and defenceless in negotiating and reproducing heterosexual relations [31], while recognising the significant economic constraints in their lives.

3.2. Behavioural and Structural Change

Tackling gender inequalities is central to any effective intervention that seeks to reduce IPV [32]. Much of the work around transforming gender norms and attitudes has been based on Paulo Freire's theorisation of dialogue and critical thinking [33]. Broadly this argues that through engaging people in safe social spaces in dialogue and discussion they can start to understand not only the behaviours that place them at risk of violence, but more importantly the underlying factors driving this behaviour [34]. In so doing they can collectively create new identities that are not so tightly bound to the ones of masculinity and femininity that have shaped their risk; essentially they can start to develop new ways of conceptualising what it means to be a man or a woman [34]. This can be understood as both an internal psychic process, as well as a broader social process of developing new identities [35]. Freire's [33] work also suggests that these processes of identity work and behaviour change generates forms of social action, both individually or collectively through community mobilisation. Small group intervention processes tend to focus on individual social action and behaviour change, while wider community mobilisation emerges through sustained support and community engagement.

For small group processes increasing research has also highlighted how challenging social contexts limit the ability of men and particularly women in act in new ways [20, 36]. In South Africa the Stepping Stones evaluation showed the effect of a substantive gender transformative intervention by reducing men's perpetration of IPV after 24 months; however

the intervention showed no sustained impact on women [37]. One argument to explain the lack of impact on women was their high economic dependency on men [18, 38].

Recognising the need to simultaneously tackle gender inequalities and poverty a number of IPV prevention interventions have been evaluated. The IMAGE study in rural South Africa combined a microfinance intervention with a gender-transformative intervention for women. After two years women in the intervention reported a 55% reduction in IPV experienced [39]. Similarly, a Village Savings and Loans Association (VSLA) intervention in the Ivory Coast for women added a couples intervention to reduce violence, consisting of 8 session 'gender dialogue groups' for women and their spouse, and evaluated this in a RCT (n = 1198 women randomised). While not showing positive results overall (overall the effect was non-significant and the reduction in physical and/or sexual IPV was 8%), it did show women who attended more than 75% of sessions with their male partner, experienced a 55% reduction in physical IPV, although this was not seen in the high adherence group for sexual IPV or the combined measure [40].

Yet similar interventions for young people have struggled to attain strong outcomes; microfinance interventions tend not to work for young people as they have high levels of mobility [21, 41], other approaches have sought to increase savings [42]. However one study with younger women in rural Uganda reported a reduction in coerced sex amongst female participants using a combination of economic strengthening interventions, including livelihoods training and microfinance [43]. There are also limitations to the reach of microfinance based interventions as these can only be built on existing well managed microfinance schemes, and these have limited coverage. Cash transfers have also been explored, but the major limitation of these is their cost. South Africa already has taken to scale through social grants programmes, particularly child support grants up to age 18, without clear impact on HIV incidence and violence.

4.0 Rationale for the selection of interventions

4.1 Gender Transformative:

There is a clear rationale for IPV prevention interventions to seek to transform gender relations, norms and attitudes amongst participants. While there are a number of short interventions of around 6 hours based on cognitive behavioural theories of change, these have shown no evidence of impact on IPV [32]. Interventions therefore that seek to transform gender relationships, premised on assumptions of dialogue and discussion, are recognised as being the basis of any successful IPV prevention intervention [44].

Stepping Stones, alongside being evaluated in the Eastern Cape in South Africa and showing reductions in alcohol use at 12 months and men's perpetration of IPV at 24 months [37], has also been evaluated globally and shows promise [45]. As such, it provides a solid foundation programmatically to build off a well-established intervention.

4.2 Sustainable Livelihoods

In accordance with the theoretical understanding that contexts of poverty and livelihood insecurity heighten the experiences and perpetration of IPV, strengthening livelihoods to reduce IPV is also critical.

Often interventions to strengthen livelihoods have narrow conceptualisations of livelihoods [21]. The sustainable livelihoods framework recognizes that people construct a living through drawing on various forms of capital, often identified as: financial capital, human capital, social capital, natural capital and physical capital [46]. Yet typically livelihoods interventions are narrowly focused on economic and human capital, excluding the importance of other forms of capital [21].

Creating Futures uses the broad conceptualisation of livelihoods to support young people to think through the multiple forms of capital they could draw on to construct or sustain a stronger livelihood [46].

4.3 Combining Interventions: Reviews of interventions and cross-sectional analyses clearly highlight the importance of combining gender transformative and livelihood strengthening interventions to improve IPV and HIV-risk behaviour outcomes [47]. Most clearly in a cross-sectional study comparing a control arm, a microfinance arm and a microfinance plus gender empowerment arm to each other, the impact on IPV amongst women was only seen in the combined microfinance plus gender empowerment arm [48].

6.0. Intervention methodology

6.1 Combining Stepping Stones and Creating Futures:

The **purpose** of the combined intervention is to both provide the necessary skills for strengthening relationships and building gender equity for women and men which are essential for IPV prevention, and provide a means of alleviating the grinding poverty which poses a barrier to women's ability to use informational and attitudinal empowerment skills and messages.

The **intervention methodology** will include a total of 21 sessions: 10 sessions of Stepping Stones delivered before 11 sessions of Creating Futures. Sessions are all approximately three hours long and are delivered twice a week, over approximately 12 weeks. Both interventions are delivered primarily to single sex groups of about 20 people and use a similar participatory methodology.

The key sessions of Stepping Stones cover: gender and peer influences our actions; sex and love; conception and contraception; STIs and HIV; safer sex and condoms; GBV; motivations for behaviour (including influences of alcohol and poverty); and communication skills.

The key sessions of Creating Futures cover: my life and the resources I have used in my life and livelihood, setting medium term livelihood goals and the need for assets for livelihoods and coping with crises; social resources for livelihoods (trust and community participation); education and learning including past experiences and how to build on these; getting and keeping jobs including work expectations and how ones on own behaviours may impede or increase our ability to get a job and to keep it, appropriate work opportunities and increase owns own ability to market ones skills and apply for work and overcome challenges in job

seeking and maintaining a job; income generating activities and how to identify viable business opportunities, the resources necessary to respond to such opportunities, basic business principles and business risks; saving and coping with shocks including spending patterns and strategies for saving, and causes and consequences of getting into debt and ways of overcoming debt.

6.2 Relief Fund

In addition to the structured and manualised intervention the project will establish a 'relief fund'. This relief fund will provide small amounts of immediate relief for participants during the intervention component of the project for immediate and pressing challenges that young people may experience. A significant and on-going issue in urban informal settlements are crises such as housing burning down. As the intervention's facilitators will engage with participants on a twice-weekly basis, they are likely to come across participants facing immediate and pressing challenges, over and above their daily lives, which require a humane response to provide small amounts of immediate support. In order to provide some ability to relive these pressures and to respond in a humane way, the team will establish a relief fund, totalling R10,000.

The relief fund will be overseen by three project members (one from each organisation – HEARD, MRC, Project Empower). It will be able to provide a maximum of R1000 to a participant who faces an immediate life crisis such as: house burning down; an immediate personal medical crisis, which the state cannot respond effectively to.

This fund only aims to provide immediate relief to a participant during the intervention period (when there is regular contract with participants), which Project Empower will support directly. A clear set of guidelines will be developed. In the pilot (see 6.3) the project established a similar process. Over the intervention period of approximately 3 months, with 232 people the fund was used three times:

- To buy shoes for the sister (aged 7) of a participant who's both parents had died to allow the sister to attend school. The participant had also applied for a social grant which was being processed at the time of request;
- A private consultation with a gynaecologist. One participant had a recurring vaginal infection. They had repeatedly sought treatment through the public system. The project paid for a consultation with a private gynaecologist and the prescribed medication;
- A participant had a seizure shortly after a session. They were currently in care of the state system. The project paid for a private consultation which enabled referral into the state system to a tertiary hospital and diagnosis of epilepsy and subsequent medication

None of these could substantially affect the outcomes of the intervention. A major criteria is that participants have sought treatment/support extensively through the current systems. Moreover, given a duty of care to participants established during the trial these low levels of support provide a way of the team providing relatively little inputs, which have major impacts.

The relief fund will be overseen by three team members and will adhere to all financial reporting and auditing requirements. Each 'use' of the relief fund will be recorded and documented for future review.

6.3 Pilot research and field testing

The SS CF combined intervention was piloted among young adults in Durban informal settlements in 2012-13. 123 women and 110 men were recruited and interviewed on two occasions and then invited to participate in the intervention. They were then followed up 6 months later and `12 months later. Overall retention at 12 months in the study was 88%. Data suggests that attendance at sessions was approximately 60%.

The results of the pilot were assessed in long term qualitative research and observational research and have been published [49-52]. The analysis showed that men's mean earnings in the past month increased by 247% from R411 (~$40) to R1015 (~$102, and women's by 278% R 174 (~$17) to R 484 (about $48) (trend test, $p<0.0001$). There was a significant reduction in women's experience of the combined measure of physical and/or sexual IPV in the prior three months from 30.3% to 18.9% ($p=0.037$). Both men and women scored significantly better on gender attitudes and men significantly reduced their controlling practices in their relationship. The prevalence of moderate or severe depression symptomatology among men and suicidal thoughts decreased significantly ($p<0.0001$ and $p=0.01$) [13].

7.0 Study methods

7.1 Objective of the RCT

i) The **primary objective** is to determine the effectiveness of the combined intervention in reducing IPV experience in women and perpetration by men, including reducing controlling behaviours.

ii) The **secondary objective** is to determine the impact of the combined intervention in strengthening livelihood seeking activities, improving mental health reducing sexual risk taking and reducing participation in crime due to lack of money.

7.2 Study design

The study is a randomised controlled trial with two arms:

1. Stepping Stones and Creating Futures
2. Control communities (cash incentive for study participation and delayed intervention)

The control arm will be given a cash incentive for study participation which is large enough to incentivise participation in interviews in the absence of an intervention over the two years prior to them being offered the intervention.

7.3 Setting

The study is set in informal settlements in and around eThekwini (Durban).

7.4 Cluster Definition/Inclusion

A cluster will be defined as a discrete urban informal settlement.

Eligibility criteria for informal settlements:

* Informal settlements in the eThekwini Municipality.
*Informality is defined by not having formal service provision within the home e.g. no electricity legally supplied, and no piped water to housing.
*Project Empower have assessed that it is safe to work in these communities

Another criteria – although hard to 'enforce' or assess is that no large development/intervention studies or programmes are identified at recruitment into the intervention

The nature of urban informal settlements in eThekwini is such that they are typically discretely geographically bounded; in essence they tend to be in clearly defined spaces. The variation in size of informal settlements is dealt with in three primary ways:

1) Small informal settlements close to each other will be clustered together to form a larger informal settlement cluster where we can recruit n=40 participants
2) Large informal settlements, if possible, will be split into separate clusters using naturally occurring boundaries and space to limit the potential for contamination (although this is a minor issue in this study as it is group-based)
3) In analyses we will account for variation in baseline characteristics of clusters – although there is nothing to suggest that size of informal settlement will vary measured characteristics

Clusters will be identified using a list of urban informal settlements provided by the Municipality. These name and provide basic information about all informal settlements in eThekwini, including location and approximate number of residential dwellings. While contamination is a concern, as it is a group intervention – rather than community mobilisation – spill over effects are likely to be minimal.

Given the challenging nature of working in urban informal settlements we will identify clusters based on pragmatic decisions around security and safety.

7.5 Inclusion criteria

Participants must be normally resident in an informal settlement, aged 18-30 years, not in formal employment, able to communicate in the main languages of the study (isiXhosa or isiZulu) and not suffering from a mental deficit (learning difficulty, mental illness or substance abuse) which would impair their ability to consent to participation in the trial.

Our age grouping is based on the requirement that participants provide informed consent, those under 18 cannot do so and require parental consent to participate, which may be challenging in informal settlements where young people do not live with their parents. Our pilot data suggests that an upper-age limit of 30 is reasonable; while the majority of participants are under 25, a significant minority were older and faced similar life challenges.

7.6 Randomisation and blinding to study arm

Randomisation will be undertaken by cluster after clusters have agreed to participate in the study. Community gate keepers will provide permission to work in a cluster/informal settlement (see 9.1 below). Clusters thereafter will not be blind to their study arm.

All clusters will be allocated numbers and the randomisation will be performed by Esnat Chirwa, MRC biostatistician, using a system of numbers. At the time of randomisation she will not know which number is allocated to which cluster. We are not doing public randomisation because of political sensitivities and that clusters are within wards, rather than wards themselves.

7.7 Sample size and sample size calculation

There will be 17 clusters in each of the two study arms.

7.7.1 Sample size calculation:

In the pilot study conducted in 2012-13 the past year prevalence of physical and/or sexual IPV perpetration and victimisation was 45% among men and 41% among women. These levels of violence are exceptionally high by South African standards, so we have modelled the sample size on a range of possible baseline rates (see the table). The sample size assumes 14 will be followed up per cluster (of the 20), but figures are robust to a follow up of only 12 in each cluster. Assuming a coefficient of variation k=0.2 and modelling 80% power. The table shows that with 14 male (and 14 female) participants per cluster and 16 clusters we will have power to detect a range of possible incidence and impact scenarios and to analyse men and women separately (see table). Our power will be further enhanced by having multiple assessments and an additional two clusters.

IPV incidence (12 months)			# of clusters required by arm
l1	l2	power	
36	29	80	16
45	36	80	15
41	33	80	16
24	19	80	14
18	14	80	13
30	24	80	15

7.8 Study's main outcomes

Primary outcome:
The past year incidence of IPV (perpetration of physical and/or sexual IPV for men and victimisation for women), including change in controlling behaviour.

Secondary outcomes
gender attitudes (more equitable)
depression (past week)

suicidal thoughts in the past month
quarrelling in last 12 months over drinking
problem drinking
last sex with main partner
transactional sex in last 3 months
condom use on last sex
mean earnings in last month
stole in the last month due to lack of money for food
Tertiary outcomes: other livelihood strengthening outcomes
Frequency of livelihood strengthening efforts
Work stress mean score
Feelings about work situation mean score
Receiving a grant
Crime participation score
Very difficult to find R 200 in an emergency

7.8 Questionnaire for main outcome assessment

The primary and secondary outcomes will be measured using a standard questionnaire. Separate male and female questionnaires are available for baseline (Appendix 01 – male; Appendix 02 – female) and 12 and 24 months (Appendix 03 – male; Appendix 04 – female).

The primary outcome for women will be assessed using standard measures developed by the World Health Organisation for its multi-country study [53] and for men those developed and tested in the UN multi-country study on men and violence [54]. These have been tested in South Africa over many years in different populations and most recently used in the pilot of Stepping Stones and Creating Futures (SS CF pilot) [49].

The background variables, secondary outcomes measures and other outcomes were used in South Africa in the SS CF pilot and elsewhere by the Gender & Health Research Unit (and others). The questionnaire, and its translations, will be largely the one used in the pilot.

Measures for Secondary outcomes	
gender attitudes (more equitable)	GEMS adapted for South Africa
depression (past week)	CES-D
suicidal thoughts in the past month	CES-D
quarrelling in last 12 months over drinking	One item – from AUDIT
problem drinking	AUDIT
last sex with main partner	Single item – used in pilot
transactional sex in last 3 months	Measured using scale derived from Dunkle et al 2004
condom use on last sex	Single item – used in pilot
mean earnings in last month	Single item– used in pilot
stole in the last month due to lack of money for food	Single item– used in pilot

7.9 Assessment of main outcomes

The study will use self-completion questionnaires on cell phones lent to participants to collect data. The questionnaire will be administered in English, isiXhosa or isiZulu. Project staff will be available to provide further explanation or assistance.

Previously in the pilot participants used self-completion questionnaires using paper and pen. Despite general low levels of literacy almost all participants had functional literacy to complete questionnaires by themselves. The availability of project staff enabled participants who struggled with words of phrases to clarify their meaning before answering them privately.

7.10 Timing of data collection for main outcomes

The baseline survey will be administered just after recruitment of participants and follow up surveys will be administered to the learners after 12 months and 24 months.

7.11 Retention of cohort

Retention and loss to follow up is a major concern for the project given the high levels of mobility of young people in urban informal settlements and patterns of migration. We have in place a range of strategies to retain the cohort throughout the two years of follow up. Specific strategies include:

A) We will send SMSes throughout the follow up period reminding participants to contact us if they move and also enabling us to remain in contact;
B) We will call each participant at data collection points to identify where they are and how to secure an interview with them;
C) For 12 and 24 months, Project Empower will re-enter the community to secure access as for initial entry. In so doing they will identify 2 young people per community to act as 'community guides' to support identification of participants who were in the original study and help guide fieldworkers around the community
D) Participants will have provided us with details of friends and family members they are willing for us to contact if we lose direct contact with them. We will contact these people if our other strategies have failed.

In addition we have an escalating cash incentive for both the control and intervention arm. Such an approach has been used before to retain cohorts over time. For the intervention arm the cash incentive is: baseline – R100; 12 months – R150; 24 months – R300. For the control arm this will increase as such: baseline – R300; 12 months – R450; 24 months – R600.

The impact of what could be considered unconditional cash transfers is likely to be minimal. Previous research on the impact of cash transfers only show impact either when transfers are over several months, or they are of a large value and the impact has often been shown to be negligible on violence measures or inconsistent. For instance in Latin America cash transfers over time have shown mixed outcomes. One study of a long-term transfer of US$15 per month (approx. 6-10% of income) showed a marginal increase in controlling behaviours by partners, but no impact on physical or sexual violence [55]. Another of US$40/month over 6 months, showed a reduction in physical and/or sexual violence at end line [56]. Once off cash transfers have needed to be of a high value to show impact, e.g. Give Directly in Kenya provided once-off payments of US$1100 direct transfers to households and showed impacts on sexual violence [57].

As such, our incentives are neither of a long-enough duration (i.e. repeat payment every month) nor of enough significant value, to be likely to have impact on the primary or secondary outcomes of the study.

7.12 Integrated process evaluation

In addition, we will undertake ethnographic research on the delivery of the intervention. Understanding how manualised interventions are delivered by facilitators is critical to understanding how they work and the challenges of delivery in real life contexts. We will achieve this through three main processes:

1. Trained fieldworkers will shadow facilitators over the delivery of the intervention and observe how they deliver the intervention, with a focus on content and methods of delivery, as well as the issues discussed (see Appendix 15 for detail). As this is ethnographic participatory research the fieldworker will participate in groups and make written notes, before recording thoughts into an electronic recorder outside of the intervention setting.
2. In-depth one-on-one interviews will be conducted with facilitators (2/facilitator) on their experiences of delivering the intervention in informal settlements, reflecting on similar issues as are observed for (Appendix 16 for topic guide)
3. Focus groups (n=5) with facilitators will allow facilitators to discuss in detail amongst themselves the challenges and successes of the intervention (Appendix 17).

All interviews and focus groups will be conducted by trained research assistants in Zulu and be electronically recorded before translation and transcription into English.

Qualitative thematic analysis using standardised approaches, including data management in Nvivo will be used.

7.13 Integrated costing of the study

An integrated retrospective and prospective costing from a provider and client perspective of the study will be conducted. The costing strategy will follow the Gates Reference Case [58] approach to costing. Specific components of the costing include:

1. Retrospective costing of the development of the Creating Futures intervention. Between 2011 and 2013 CF was developed by the main trial team. Through purposive sampling of the trial team using semi-structured in-depth interviews (Appendix 19) costs related to developing CF will be identified (e.g time, resources, indirect costs). In addition, review of financial records of Project Empower and HEARD will occur. This will enable an estimation of the cost to develop the intervention;
2. Prospective costing of the intervention. During the intervention delivery a prospective costing of the intervention will occur. Financial data will be collected based on the following categories of expenditure outlined fully in Appendix 20:
    a. Capital costs (e.g. vehicles buildings)
    b. Staff costs (project team, facilitators)
    c. Transport costs (taxi and car travel)
    d. Current costs (electricity, internet, stationary etc.)

    Data will be extracted from financial records of the implementation organisation (Project Empower) and will be checked on a quarterly basis to account for any differences.
3. Time-motion data of facilitators. To understand how facilitators use their time and to estimate improvements in efficiency, we propose for fieldworkers to shadow between

6 and 8 purposively selected facilitators and record their time use based on the table in Appendix 21. This records the activities of the facilitators using paper and pencil before being translated into electronic records;

4. Social costs. Data will be collected only from participants in the intervention arm on the direct and indirect costs they may have incurred in attending the intervention (for example child care, opportunities lost etc.). Data will be collected through a two-page questionnaire administered by paper and pencil at the second to last session of the intervention. Data will be anonymised using participant codes as per the main trial data (Appendix 22). In addition, to those in the intervention arm, we will include 6 items on willingness to pay in their baseline interviews (Appendix 01 and 02).

A gatekeeper letter from the Director of Project Empower is included approving the costing study and agreeing to allow the team to access the relevant information.

7.14 Integrated qualitative process evaluation

An integrated qualitative process evaluation will also occur as part of the study. At baseline we will purposively select 40 participants (20 men, 20 women) from two intervention clusters for inclusion. These same people will be followed up at baseline (2 interviews), 6m, 12m and 18m post intervention and participant observation throughout the period as well. A separate informed consent process will also be used to separate out participation in the main study and participation in this sub-study (Appendix 24 men and Appendix 25). When we approach participants we shall make it clear their participation in the sub-study (or not) does not affect their participation in the main study.

In-depth interviews will focus on exploring the processes of change and the barriers to change in the intervention. The focus of this component will be on participants' life experiences around the intersection of gender, livelihoods and sexual risk and the impact of the intervention on these. This will include a specific focus on gender power and control in intimate relationships, sexual risk behaviours, understandings of masculinity and femininity (as appropriate), experiences and understanding of transactional sex and a focus on how young people 'get by' and survive in their everyday lives. It will also include a specific focus encouraging participants to reflect on the impact of the intervention. Specifically it will also explore the intervention and whether young people have changed or not - Appendix 26 = women's baseline interviews; Appendix 27 = women's follow up interviews at 6m, 12m and 18m. Appendix 28 = men's baseline interviews; Appendix 29 = men's follow up interviews at 6m, 12m and 18m.

They will be undertaken by same sex fieldworkers who have been trained in research and have undertaken similar research before. Interviews will take place in a private and secure location. Participants will be bought a small meal (value R100) to support rapport and relax participants. Interviews will be recorded electronically in English and isiZulu and transcribed and translated by fieldworkers.

For women and men who have completed in-depth interviews, they will also be subject to participant observation. Participant observation will be undertaken from baseline through to 18m, every second week to begin with and curtailing as time progresses. Participant observation enables 'real world' discussion and understanding of people's lives and the impact of the intervention on people's worlds [59]. Every second week a trained fieldworker will spend a day shadowing participants and talk to them about their lives as well as observe them in their everyday life, making notes in a fieldwork notebook (the frequency will decline

over time). Their discussions will be guided by Appendix 30 for men and Appendix 31 for women and reflect the overall objectives of the study and the in-depth interviews.

10 women already enrolled in the qualitative sub-study, will be offered the opportunity to participate in a PhotoVoice process [60]. PhotoVoice is a qualitative methodology that uses pictures as a way to build alternative understandings of issues, particularly where language challenges exist [60]. Participants will be asked to participate in four workshops (each comprising of two half-day sessions), at baseline, 6m, 12m and 18m. Before each session, there will be a reiteration of informed consent verbally, with the offer to withdraw if they wish. The workshops will be guided by the PhotoVoice Appendix 32.

8.0 Management of the study

8.1 Investigator team and staffing

The principal investigator with overall responsibility for the study is Andrew Gibbs, he will have final scientific responsibility for the study including the design, research conduct and data analysis and reporting. The other investigators were all part of the team for the SS CF pilot study. Rachel Jewkes was the principal investigator of the Eastern Cape RCT evaluation of Stepping Stones and Yandisa Sikweyiya and Nwabisa Jama-Shai were both employed on that study and they will bring their expertise to inform this evaluation. Samantha Willan (HEARD) was also a co-investigator on the SS CF pilot study and will bring this learning to bear on the study design and evaluation. The project will hire a range of temporary staff through HEARD to administer the questionnaires, and will hire a counsellor to support participants and assist in cohort retention. Project Empower will manage the intervention and hire staff to facilitate it. The study statistician is Esnat Chirwa (MRC) who will be responsible for randomisation, data management and data analysis.

The costing component of the study is supported by LSHTM staff. For the costing component the PI is Prof Anna Vassall, who has over 20 years of work globally on costing, including TB costings in South Africa. Giulia Ferrari is a research fellow in SaME at the LSHTM. She has over 10 years' experience in evaluating the effectiveness and cost-effectiveness of interventions for the prevention of violence and for the support of violence survivors. Mike is a research fellow at HEARD and has been conducting primary quantitative and qualitative research in the field of healthcare and HIV since 2012. The oversight of this component remains with the trial PI, Andrew Gibbs.

9.0 Ethics

This research proposal is structured in accordance with the ethical principles provided by the World Medical Association Declaration of Helsinki (last updated in 2013), and the Belmont report (1979). Both these documents emphasize respect for person's autonomy, justice, beneficence, and non-maleficence (do no harm) in the conduct of research with human participants.

Ethical approval for the study will be sought from the South African Medical Research Council's Ethics Committee and the University of KwaZulu-Natal's Humanities & Social Sciences Research Ethics Committee.

This study aims to determine whether the combined Stepping Stones and Creating Futures interventions are effective in empowering young women in informal settlements to decrease their exposure to IPV and young men in informal settlements to lessen their perpetration of IPV including controlling behaviours. This is premised on the assumption that this combined curriculum will build a critical approach to thinking, learning and promoting healthy sexual behaviours and conflict resolution skills and ways of strengthening livelihoods. We therefore assume that this curriculum will enable the research participants to translate the skills learned into multiple and shifting livelihoods on strengthening livelihoods.

This trial has been designed to ensure that the project does not expose participants to more than minimal risk (more than everyday risk). The study design has measures in place to minimise the potential of harm to participants and be able to respond to any adverse consequences i.e. emotional or psychological harm that may result from the questions that will be asked in this study (see below).

We believe the findings of this trial will advance knowledge on the effectiveness of the combined curriculum of Stepping Stones and Creating Futures intervention among young people in informal settlements.

We expect that participants may benefit from participating in this trial. The findings of the pilot which was conducted in 2012-2013 suggest that young people derive important benefits from this combined intervention, as shown above (see **6.2 Pilot research and field testing).** Additional to this, the Stepping Stones behavioural intervention tested in a RCT was proven to be beneficial to the young people in the rural Eastern Cape. Participants who went through the Stepping Stones workshop demonstrated improvement in HIV-related knowledge, gender-based violence attitudes and behaviours and practices at 24 months (last evaluation stage) as compared to the control group [37]. Therefore we anticipate that participants in the intervention arm will benefit from going through the combined intervention. We plan to provide the combined intervention to the participants in the control group after we have done the last evaluation at 24 months.

All data will be stored at HEARD's and MRC's offices in locked filing cabinets or in password protected computers. Data will be kept in a secure store for at least 5 years, after it has been analysed and different reports have been written. The intervention implementers and research assistants (where data is not anonymous) will sign a confidentiality agreement (see Appendix 05).

All project staff will receive training – on gender, gender-based violence, and HIV and research ethics – prior to implementing the trial.

The following measures will be put in place to ensure that the study is conducted in an ethical correct manner.

9.1 Community mobilisation and access

Community mobilisation, access and recruitment of participants will be led by the implementing organization Project Empower, a gender and HIV non-governmental organization based in Durban, South Africa. Project Empower has extensive experience working and delivering a range of interventions in informal settlements. Thus in accessing the trial clusters (communities) and recruiting participants, this project will draw from Project

Empower' s experience and knowledge of the trial setting to ensure that this process is conducted in an ethical correct and culturally appropriate manner. Throughout the process of accessing communities the study will be described as a project that hopes to help young people improve their lives – as such it will not focus on either the violence or livelihoods aspects of the work.

Accessing communities will be done through a process of community engagement and mobilization, whereby Project Empower will identify key community organisations – ward councillors, local development committees and so forth and request permission to work in the communities. We will provide permission letters for working in communities (Appendix 07) to ethics committees. Without permission letters from Ward Counsellors conduct this research and intervention we will not be allowed into the communities. We will ensure Ward Counsellors remain fully aware of the study and progress through yearly meetings hosted by Project Empower, enabling ongoing access and community buy-in.

9.2 Recruitment of participants

Once permission to access communities has been granted and clusters have been identified and randomised Project Empower will host a number of open community meetings where they will brief community members about the trial, its nature and design. Community meetings are relatively regular in informal settlements and as such are well known. Also, flyers with adequate information about the trial and project contact details will be handed out during the community meetings. During these community meetings, Project Empower will request those eligible and interested in the trial to contact the project staff by sending free 'please call me' messages from cell phones. The majority of young people in informal settlements have access to cell phones. Those who do not can easily access cell phones through vendors at the side of the road who offer low-calls for people. In addition, 'please call me' messages are free to send, as such young people are likely to be able to borrow cell phones to make initial contact.

In addition, Project Empower will hire two young people from the local community to support recruitment. In clusters where there will be an intervention, these two will become facilitators delivering the intervention. These young people will also support recruitment in the communities and hand out flyers to potential participants encouraging contacting of Project Empower.

Those who made contact with the project staff will then be invited to meet with the project staff in a central location in their community. These spaces will vary depending on communities – but could include a community hall, a spare room off a shop, or sports field. There will be a two day window where Project Empower and HEARD staff will be at this location. Upon arriving potential participants will have further details about the trial will be explained to them, after which they will be invited to participate in the trial (e.g. what it entails, length of study etc.). Informed consent process will only occur after initial agreement of participants.

9.2 Informed Consent

All research participants will be asked to give written informed consent (consent forms in Appendix 06) before participating. Adequate information about the trial will be given to prospective participants prior to giving consent. They will be informed of the purpose of the

trial, procedures involved, risk and benefits of the trial and their rights as participants. Prospective participants will be informed that they do not have to participate in the trial unless they are happy with the trial procedures and understand what the trial is about. All participants will be told that participation is voluntary, that they may withdraw at any stage, skip any question in the research and that there will be no adverse effects on them should they decide not to participate.

For the success of the project we require all research participants to agree in principle to multiple interviews (i.e. baseline, 12m and 24m) - although they may change their mind. For this reason we propose to stagger the consent process over a period of time and ensure that no interviews are conducted on the first day that a person has been introduced to the idea of the research.

The participant information leaflets consent forms are written in simple English, however to enhance understanding, the explanation and discussion may be in isiZulu, isiXhosa or English depending on the participant's language preference. A researcher will be present throughout the informed consent process and will clarify any questions the participants are not clear about.

Participant in-depth interviews, observation and PhotoVoice

The participant indepth interviews, participant observation and PhotoVoice process (only for women) rely on exploring participants lives in great deal, and building up rapport with participants. As such there are additional ethical considerations. First, we will take participants selected through a second informed consent process only for this component (beyond the quantitative research informed consent) (Appendix 24 and 25). Second, we will continually check in with participants around their willingness to be involved in the research, this will include before any sessions are run and through ongoing verbal consent processes by research team members. At each point it will be made clear to them that they can choose to opt out of the study with no harm coming to them.

As the team will build relationships with participants over this time, it is likely that there will emerge instances where participants inform researchers about harms that have happened to them (for instance being beaten up). If participants disclose issues that require further intervention the researcher will alert the PI of the study and they will agree a process, and where appropriate inform the ethics committees. Strategies could include: referral to counselling, support to report issues to the police, support in going to hospital or so forth. These will be supported at the project's expense.

Costing and facilitator research

Both the costing study and the research on the delivery of the intervention relies on observation, interviews and focus groups with facilitators. As such one integrated informed consent will be provided for facilitators (Appendix 18) before participating. They will be informed of the different methods of research (observation, time motion analysis, interviews and focus groups) and the purpose of the research – to understand intervention delivery and costing the intervention and the risks, benefits and rights as participants. They will be informed that they do not have to participate in the study if they do not wish to.

Interviews with trial team members around the development of Creating Futures for the retrospective costing requires a separate informed consent (Appendix 23). All potential

interviewees will be provided with an informed consent outlining the methods of research, the purpose of research and their rights as participants. They will be informed that they do not have to participate in the study if they do not wish to.

In addition, we have modified the informed consents for participants in the main study (Appendix 6) to reflect that they may be observed as part of this study and the additional set of questions that the costing component entails.

9.3 Maintaining the cohort data linking

In order to maintain the cohort it will be necessary to collect personal information and store this. We propose to record name, address, cell phone number and the cell number of two close friends or family members. This will be kept in a separate computer which will include in the database for each participant their study ID and will be password protected. All participants will be allocated unique study IDs. Only the study ID will be kept with the completed interview files. After the link is no longer needed all the cohort tracking details will be erased. Participants will be informed that it is necessary to keep this information for the study.

9.4 Confidentiality & anonymity

All participants will be assured that the information they provide in the trial will be handled confidentially and findings reported with complete anonymity. Once the data has been uploaded and sent to the MRC and HEARD it will be stored in password protected systems.

This trial will use self-administered cell phones for collecting the quantitative data. Electronic handheld devices have been used by the MRC Gender and Health Research Unit in previous research with young and adult men and women in the Eastern Cape, KwaZulu-Natal and Gauteng, and with great success with both literate and illiterate people.

Use of cell phones in this trial will ensure anonymity of information given by participants as they will not write their names in the cell phone. Participants will have unique study codes that will not be linked to their names and thus their responses will not be traceable back to them. Using cell phones will allow us to collect data anonymously and this will therefore protect both researchers and participants should the latter disclose illegal activities or practices in the interviews.

However, we recognise that there are limits to confidentiality and have highlighted this in Appendix 06 – Informed Consent. Specifically, we have included the words: “If during a workshop the person running the workshop feels you may be about to provide too much information (such as an intention to harm someone else in the future) they will warn you not to reveal any further information. If you did continue to tell them about this, we may be required to report the information to the authorities (e.g. Police or Social Workers).”

We assume that this is unlikely to happen. Facilitators will be trained to stop participants in workshops before they reveal issues that may need to be reported, however there are cases where unsolicited reports that may emerge [61]and if participants do report such activities to fieldworkers, facilitators or team members we may have to report onwards. In an unlikely event that a disclosure of incriminating information is made, the principal investigator will report this information to the ethics committee for advice and guidance. The principal

investigator and the EC will discuss the gravity of the disclosure and the course of action to be taken.

Research with facilitators and costing
To ensure confidentiality the data on facilitators (both costing and delivery) will be kept away from the implementing organisation (Project Empower) until the data's anonymity is secure. Research assistants will report to the PI and provide the PI with data, who will ensure anonymity for the participants before the data is shared more widely within the project team. Facilitators will be promised that this information will not be provided to Project Empower in any way that could lead to facilitator's being identified nor be linked to their job.

In-depth interviews, Participant observation and PhotoVoice
To ensure participant confidentiality, any notes and audio recordings will be written up as anonymised data, with false names. During PhotoVoice a key component is ensuring anonymity of photos, through strategies such as not taking photos of faces, this will be discussed extensively with participants during the study (Appendix 32).

All field researchers (data collectors and facilitators) will be required to sign an Agreement of Confidentiality (Appendix 5). This agreement will bind them to uphold the confidentiality of all information encountered during the research.

All computers and study databases will have password authentication for access. Data from the trial will be anonymously processed and written into a study report and also published in peer reviewed journals. Study data, informed consents and confidentiality agreements will be kept at the HEARD's & MRC offices for a period of 5 years after writing the findings of the trial.

9.5 Potential risks related to the interviews
Participants will be guaranteed that the information will be kept confidential. At the point of data analysis information will be anonymously processed in order to minimise the possibility of data, in particular disclosed illegal behaviour, to be linked back to individual participants. Further we will not collect sufficient information about any act in the questionnaire to enable a prosecution of any crime.

Research with facilitators
As facilitators are employees of the implementing agency, there is significant risk to them in their professional life. We will ensure that no data is seen by the implementing agency on the experiences of facilitators until it has been full anonymized.

Indepth Interviews, Participant observation and PhotoVoice
As participants build up relationships with the research team over the course of participant observation and PhotoVoice sessions, there is a risk that they will disclose information that is illegal. As with other studies where the team have undertaken qualitative research on illegal behaviours [20, 30, 61] we will make participants aware when they start telling stories which we may be forced to tell others (e.g. social workers, police) to reduce this from happening. Any instances where we may be forced to compromise the privacy of will be discussed with ethics committees beforehand [61].

9.6 Harm due to the study

We will collect data on potential risks related to the study. It is a sad fact in South Africa that large randomised controlled trials always experience deaths of study participants. It is critical that these are investigated and shown to be not study related. For example, during the pilot study of 232 participants who we intended to follow for a year there were three deaths and one participant went to jail. Similarly in the first Stepping Stones evaluation there were 16 deaths in 2800 people followed for 2 years. We investigated all these and found none to be study related. The investigation of study participant deaths will be conducted by the counsellor. At an appropriate time, he or she will be asked to visit the family (or friends if no family are available) to collect information on the circumstances of the death. A report will be sent to the ethics committee. We will inform participants that if there should be a death that they learn of we must be informed and we may also learn of deaths when conducting follow up interviews. We are not administering medication to participants and the basic interventions are known to be safe (Stepping Stones has been used with 10s of thousands of participants globally) so we do not anticipate any study related deaths.

Given that this is a study on violence we will also undertake investigations for any reported hospitalisations or escalating violence that are reported to study staff. The counsellor will at an appropriate time collect information on the causes of hospitalisation or escalation of violence and provide a written report that will be forwarded to the ethics committee for their review.

This research includes a number of sensitive topics. It has been well established that there is a potential for harm to participants in research on gender-based violence. The most important concerns relate to the risk of re-victimisation of women for engagement in the study; the risk of retribution against perpetrators disclosing in these studies; and the risk of psychological distress to participants through being asked to re-remember traumatic events.

The World Health Organisation developed guidance on safety in conduct of research in this area [62] and guidance for safe conduct of research on male perpetration of sexual violence has been developed by the Sexual Violence Research Initiative (Sexual Violence Research Initiative, forthcoming). These documents recommend that the nature of gender-based violence research be concealed from non-interviewees until after the completion of fieldwork. The risk of retribution against men disclosing perpetration is guarded against by using self-completion for disclosure of acts that are socially stigmatised or involve the most severe forms of violence. This is implemented here. In the few cases where self-completion cannot be implemented due to illiteracy, fieldworkers will be trained to keep information confidential. The third area of risk relates to psychological distress experienced by participants. Research from diverse global settings (such as Nicaragua and South Africa) has shown that women victims of violence are saddened by talking about their exposure to violence but overwhelmingly they welcome a chance to talk and many describe the research interview as a life changing occurrence, further men who have raped can find discussing it in interviews makes them realise that it was wrong [53, 63-65]. Thus research has shown that if these guidelines are followed there are minimal risks attached to survey research on gender-based violence [63, 66]. The present study has included the guidance from these documents in its design. However, in cases where participants demonstrate distress or report being emotionally impacted by the research questions or intervention, they will be provided professional support as explained below.

9.7 Intervention Challenges

In the pilot a number of women described having arguments with their main male partners about their participation in the intervention (rather than research). This was related to the fact that they had been unable to discuss openly with their partner their participation. To minimise potential risk and harm participants may face we have added in additional guidance and focused discussion with facilitators around supporting participants to actively think through discussing their participation with partners or family members and the potential benefits and risks of this.

9.8 Referral

Project Empower will employ a counsellor who can be accessed by all participants via a cell phone (please call me messages) and will be able to provide support over the period of the study. If referral to another agency is required (e.g. to a Thuthuzela Care Centre after rape) the counsellor will be able to facilitate this. This will be given to all study participants. The decision to use Project Empower is that participants will have greater contact with Project Empower over the study and will be more likely to contact Project Empower – rather than HEARD – in the case of concerns about their wellbeing.

All participants will be informed that should they feel they have been upset or affected negatively by the research questions or content of the intervention, they are welcome to speak to the study counsellor at no cost to them. All participants will be provided with the study counsellor's number for them to contact. The facilitators and research assistants will be trained to identify participants who are visibly distressed during the interviews or intervention sessions and with their permission refer them to the trial counsellor.

9.9 Research reimbursements

Participants in the intervention arm will receive a financial reimbursement of R100 for participating in the research. This will be given after each interview. No incentives will be provided for intervention participation, but if an out-of-cluster site is needed for holding the workshops we will support travel costs to the venue. Refreshments for participants will be provided during the workshops.

Those participating in the control arm will receive R300 per interview. This amount has been chosen as it is a considerable incentive to participate, and we anticipate that it will be similar to the child support grant monthly amount in 2015 (which was R320 in 2014).

At follow up data collection points the amount of financial reimbursement and incentive for both arms will increase. For the intervention arm this will increase as such: baseline – R100; 12 months – R150; 24 months – R300. For the control arm this will increase as such: baseline – R300; 12 months – R450; 24 months – R600.

Retention in studies, particularly for control arms is highly challenging. Financial incentives have been used previously to improve retention. Research elsewhere has shown that financial incentives alone are not enough to prevent violent experiences or practices and so we anticipate that we can meaningfully incentivise the control arm without interfering with the study main outcome.

Facilitators and trial team members will receive no reimbursements for their time being interviewed, observed or during focus groups. If they need to travel for any specific research reason this will be reimbursed.

9.10 Working in informal settlements

There are significant challenges to working and researching in informal settlements. To minimise these risks to our fieldwork team we build on the experience of delivering the pilot. At baseline Project Empower will have already secured access and provide us with detailed information about the local community, fieldwork will take place in a secure location and none of the fieldworkers will carry cash. All incentives will be transferred via cell phone through providing a reference number.

At 12 and 24 months Project Empower will once again re-establish entry to these communities to ensure security. In addition, they will hire community guides who will provide additional support as fieldworkers move around the community identifying participants. This has proved incredibly successful previously as community guides can provide local knowledge and are more likely to ensure safety.

Other strategies include fieldworkers only carrying cellphones for data collection – rather than laptops or tablets. Cell phones have a value of R1000 and are easy to hide, compared to lap tops or tablets. We also brief fieldworkers on fitting in e.g. by wearing appropriate clothes.

9.12 Additional Review bodies

The University of KwaZulu Natal will also give ethics approval through its Human and Social Science Ethics Research Committee.

9.13 Similar studies

We are not aware that the MRC Ethics Committee has previously been asked to approve a similar study.

10.0 Data handling and analysis

10.1 Data management and data analysis from the main RCT

All data will be co-owned by HEARD, the MRC and Project Empower.

Data will be uploaded by wireless from cell phones. The cell phone system is likely to be Mobenzi researcher. This is an online system that will automatically upload data if a connection is available. Given that this is in urban settings it is highly likely that a 3G connection will be continually available. If no signal is available, the cell phone stores the data until a connection is available. The cell phones have approximately 8 hours of battery time. Every evening they will be charged in readiness for the next day of work.

There is no direct data entry stage. The data is wireless uploaded onto a web-based data base that is preconfigured into the necessary dimensions. On a weekly basis the data base will be downloaded on to a staff computer in excel before being entered into STATA. Data will be managed, cleaned and stored by the Medical Research Council Gender and Health Research Unit. Data analysis for the main study outcomes will be conducted by the MRC Biostatistics Unit.

10.2 Data analysis

The main analysis will be by intention to treat but a *per protocol* analysis will also be conducted as a secondary analysis.

Any participant who responds affirmatively to any one of the five questions on physical intimate partner violence or three questions on sexual intimate partner violence in the past 12 months at the 24 month data collection points will be deemed to be an incident case of IPV victimisation (if female) or perpetration (if male).

IPV incidence will be compared between the study arms. The person years of exposure will be estimated as the time from the baseline to the first report of IPV (if this is reported during the study) or to the last interview, if they remain IPV free at the end of the study. Separate analyses will be done for males and females. The primary analysis will be carried out by fitting a Poisson regression model, which will terms for age of participant, cluster, baseline prevalence of IPV (for males or females) and treatment (arm). For each secondary outcome a Generalised Linear Mixed Models (GLMMs) will be fitted with similar terms as in the Poisson regression model for the main outcome. These will be fitted for time from baseline to interview (12 months and 24 months). Secondary analysis of the main outcome will also be done using a multi-level model for change. Generalised Linear Mixed model for binary outcome will be used.

Analyses for secondary outcomes will follow the same approach for variables where incidence can be measured. For outcomes using scales, the difference in the score/scale between baseline and 24 months measure will be assessed. For each of the scales a linear mixed model will be fitted with fixed terms for treatment arm. Separate models will be fitted for males and females. The scores will be directly calculated from the component items, while the scales will combine the items using weights determined by carrying out a principal component analysis on the items at baseline (separately for males and females), and using the loadings for the first principal component as the weight for each item. The baseline weights (separate for males and females) will be used to construct the scale at each time point. These analyses will firstly be carried out in the ITT population and then repeated for the per protocol population.

For any categorical variables where incidence cannot be calculated the following approach will be taken. First a cluster level analysis will be carried out with the response being the overall cluster proportion of participants who reported the practice, with this cluster level proportion being calculated separately for males and females. This response will be compared between clusters using an analysis of covariance model with terms for the overall cluster proportion of participants (males or females respectively) who reported the practice at baseline and treatment arm. The model will give the rate difference for the practice for participants in one arm versus those in the comparison, together with 95% confidence limits and a test of the null hypothesis that there is no difference between the two study arms in the proportion of participants who reported the practice. Separate estimates will be given for males and females as for the other responses. Further individual level analyses will be carried out by fitting Generalized Linear Mixed Models to the binary outcome variable. The model will have fixed terms for treatment arm and whether or not the participant reported the practice at baseline, with separate models fitted for males and females.

Costing Analysis

In order to estimate the total cost of the SS/CF intervention, the cost of both the retrospective and prospective components of the study outlined above will be analysed. This includes the direct and indirect costs from the perspective of the service providers and the participants. Research related costs will be excluded from the analysis.

In order to conduct the cost-effectiveness analysis, incremental cost-effectiveness will be calculated using primary and selected secondary outcomes of the SS/CF intervention. The primary outcome in the RCT is incidence in the past year of intimate partner violence (perpetration of physical and/or sexual IPV for men and victimisation for women), including change in controlling behaviour. Key secondary outcomes include gender attitudes; depression; problem drinking; sexual behaviour and mean earnings in last month. The time and motion data will be used together with the salary costs paid to the facilitators to identify the proportion of labour resources used and costs relating to core activities in the intervention, administrative activities and non-core activities.

Costs and outcomes are compared against the control group, who receive no intervention in the initial timeframe as set out in the RCT design. Cost-effectiveness will be assessed as the intervention cost per participant divided by the effectiveness of the intervention.

The cost data collected at different time points in the study will also be used to estimate the incremental efficiency gains as the facilitators become familiar with the intervention and the material they present. These data will be used to better understand resource use as the intervention rolls out and has implications for estimating the costs of scale-up.

We will use a standard annual discount rate of 3%, and run sensitivity analyses will be conducted using local discount rates, to check the robustness of results to these changes. Total costs will be reported in USD2017, using official exchange rates.

Concentrating on health outcomes exclusively would not do it justice and risk overlooking a large portion of its impact. Therefore impact on economic outcomes – including income, consumption, savings behaviour and preferences – will be assessed using the main analysis model, similarly to main outcomes, and analysed alongside willingness to pay. Estimation of willingness to pay will be based on participant responses to an open-ended contingent valuation question, and will include a multivariable regression analysis to identify key predictors of willingness to pay. This will not only provide a full representation of intervention impact, but also contextualise the willingness to pay results in relation to participants' socio-economic status and relevant changes as a consequence of the intervention.

11.0 Challenges

We recognise that attendance at the intervention will be voluntary, the intervention is long and it is difficult to know exactly what the level of sustained participation will be. We will collect data on attendance so that we can use this information in the data analysis. In the pilot study we found approximately 60% of sessions were attended, and this showed promise of impact. We do not expect attendance to be lower than in the pilot. We also may encounter loss to follow up. We have inflated the necessary sample size to allow for a possible 40% loss to follow up without critical loss of power for the evaluation. Retention of participants is always a challenge in cohorts and plans for this are outlined below.

Informal settlements are tricky areas to work in because they can be dangerous for staff and also sometimes have quite complex local politics. Project Empower has been working in informal settlements in Durban since it was established 13 years ago and so we are confident that they have the necessary understanding of the issues in these areas to be able to undertake the mobilisation for the study and intervention safely.

11.0 Dissemination

The trial will be registered on clinicaltrials.gov and information about the trial is available on the What Works to Prevent Violence website (www.whatworks.co.za). The Stepping Stones manual is available through the MRC and the Creating Futures manual can be found on the HEARD website [67]. A paper on the methodology used and the main study findings from the RCT will be published in international peer reviewed journal articles.

The study team will form a local stakeholder group with representatives of participating communities through the structures consulted for consent, representatives from provincial Government in KwaZulu-Natal and NGOs working in similar areas who will be informed of the trial and emerging results. One meeting of this stakeholder group will be held annually for the four year duration of the project. During these meetings, participants will be informed about project progress, consulted on challenges, and informed of findings as these emerge.

Information about the trial will be disseminated to conferences and at meetings with stakeholders in the health, violence, gender and economic empowerment fields. Multiple strategies will be used to disseminate the important learnings that will be gained and to ensure the integration of these lessons into practices at a provincial level and beyond where possible. These strategies include: meetings and workshops, written outputs including fact sheets and brochures; global dissemination and discussions via SVRI platforms and activities. Initially, meetings will be held with decision-makers, both provincially and nationally to inform them of the project and to invite them to form part of the advisory bodies. Once these bodies have been established, regular meetings will be scheduled to keep members informed of project progress and to get input on various aspects of the project. Fact sheets, briefing papers and presentations will be developed to support project activities and assist with sharing project outcomes.

Finally, a national workshop with policy makers, community members, donors and other stakeholders will held to discuss the findings of the project and map a way forward for scaling up.

In addition, the team will create a short film (approximately 5 minutes) using interviews with facilitators and participants about their experiences of the intervention and the approach. The film will be 'promotional' and emphasise positive aspects of the intervention and approach. The film rationale is outlined in Appendix 33, with a short topic guide (Appendix 34) and informed consent for the participation in the film (Appendix 35).

12.0 Timeline

	Jan-Jun 2015	Jul-Dec 2015	Jan-Jun 2016	Jul-Dec 2016	Jan-Jun 2017	Jul-Dec 2017	Jan-Jun 2018	Jul-Dec 2018
Community mobilisation in Durban informal settlements								

Gain ethics approval and access for the study								
Develop questionnaire and evaluation materials, gain ethics approval								
Intervention delivery (Stepping Stones/ Creating Futures)								
Baseline measures								
12 month follow up								
24 month follow up								
Data analysis								
Writing								
Dissemination including finalising and publishing curriculum								

13.0 Funding

The research is funded by the United Kingdom Government's Department for International development (DFID).

The total project for the budget is £800,000. The summary of the budget is provided here.

	2015	2016	2017	2018
Intervention	£150,000			
Fieldwork R1	£80,000			
Fieldwork R2		£120,000		
Fieldwork R3			£150,000	
Data analysis			£50,000	£50,000
Control Intervention				£200,000

14.0 Details of researchers

CURRICULUM VITAE FOR ANDREW ROBERT GIBBS

Title of study/ Research proposal: Stepping Stones and Creating Futures Intervention Trial

Protocol no if applicable: N/A

Designation/ Profession: Researcher, Health Economics and HIV/AIDS Research Division (HEARD), University of KwaZulu-Natal

1. Personal Details

Name	**Andrew Robert Gibbs**	Tel. no.	
Address	**HEARD, Private Bag X54001, Durban, 4000**	Work tel. no.	**031 260 7737**
		Fax no.	**031 260 2587**
		Cell phone no	**079 342 1918**
		Email	**gibbs@ukzn.ac.za**

2. Academic and professional qualifications

Degree	Field of study	University	Year
PhD	**Psychology**	**UKZN**	**In progress (being marked)**
MSc	**Social Psychology**	**London School of Economics**	**2006**
BSc (Hons)	**Economics and Development**	**University of Bath**	**2004**

3. Professional body registration number if applicable
PLEASE ATTACH COPY: N/A

4. Current personal medical malpractice insurance details [medical and dental practitioners] where applicable

5. Relevant related work experience (brief) and current position

Period	Position	Employer
2008- Present	**Researcher**	**HEARD, UKZN**
2007-2008	**Research Fellow, HIVAN**	**UKZN**
2006-2007	**Research Assistant**	**LSE**

6. Participation in research in the last three years (title, protocol number, designation) [If multiple proposals/ studies, only list those with relevance to this application, or in the last year.]

Protocol ID: N/A
Protocol title: A two-pronged service and community mobilisation intervention to reduce gender-based violence and HIV vulnerability in rural South Africa. Canadian Institute for Health Research (CIHR), 2011-2016
Designation: Co-Investigator

Protocol ID: N/A
Protocol title: Sexual & reproductive health and rights of young people living with HIV
Designation: Co-PI

Protocol ID: N/A
Protocol title: The development and evaluation of gender transformative and livelihood strengthening intervention to reduce IPV in urban informal settlements, South Africa
Designation: Co-PI

Protocol ID: N/A
Protocol title: A three-year follow up to the Community Responses to HIV/AIDS Project
Designation: Co-PI

7. Peer-reviewed publications in the past 3 years

1. Gibbs, A., Campbell, C. & Maimane, S. (2014) Can local communities 'sustain' HIV/AIDS programmes? A South African example. Health Promotion International
2. Gibbs, A., Jewkes, R., Sikweyiya, Y. & Willan, S. (2014) Reconstructing Masculinities? A qualitative outcomes evaluation of Stepping Stones and Creating Futures. Culture, Health and Sexuality
3. Stern, E., Cooper, D. & Gibbs, A. (2014) Gendered differences among South African men and women's informal sources and evaluation of information related to sex and HIV risk. Sex Education
4. Olinyk, S., Gibbs, A. & Campbell, C. (2014) Implementing global gender policy to reduce HIV/AIDS in low-and middle -income countries: Policy makers' perspectives. African Journal of AIDS Research
5. Gibbs, A., Campbell, C., Akintola, O. & Colvin, C. (2014) Creating social spaces for effective peer-to-peer communication: three case studies of the role of volunteers in HIV/AIDS communication in South Africa. Journal of Applied and Community Social Psychology
6. Gibbs, A., Jewkes, R., Mbatha, N., Washington, L. and Willan, S. (2014) Jobs, food, taxis and journals: complexities of implementing a structural and behavioural intervention in urban South Africa. AJAR 13:2, 161-167
7. Gibbs, A., Jewkes, R. & Sikweyiya, Y. (2014) "Men value their dignity": securing respect and identity construction in urban informal settlements in South Africa. Global Health Action. 7: 23676
8. Zelnick, J., Gibbs, A., Loveday, M., Padayatchi, N. & O'Donnell, M. (2013) Health Care Worker Perspectives on Workplace Safety, Infection Control and Drug-Resistant Tuberculosis in a High Burden HIV setting. Journal of Public Health Policy.34(3):388-402
9. Gibbs, A., Crone, E.T., Willan, S. & Mannell, J. (2012) The inclusion of women, girls and gender equality in National Strategic Plans for HIV and AIDS in southern and eastern Africa. Global Public Health. 7:10, 1120-1144.

10. Gibbs, A., Mushinga, M., Crone, E.T., Willan, S. & Mannell, J. (2012) How do National Strategic Plans for HIV and AIDS in southern and eastern Africa integrate gender-based violence? Health and Human Rights. 14(2), 1-11.
11. Daku, M., Gibbs, A. & Heymann, J. (2012) Representations of MDR and XDR-TB in South African Newspapers. Social Science and Medicine, 75, pp. 410-418.
12. Gibbs, A., Willan, S., Misselhorn, A. & Mangoma, J. (2012) Structural Interventions for Gender Equality and Livelihood Security: A critical review of the evidence from southern and eastern Africa. JIAS – Journal of the International AIDS Society, 15(S2): 17362
13. Campbell, C., Nair, Y., Maimane, S., Sibiya, Z. & Gibbs, A. (2012) Dissemination as Intervention: Building local AIDS competence through the report-back of research findings to a South African rural community. Antipode, 44(3), p702-724

8. Any additional relevant information supporting abilities to participate in conducting this trial. [Briefly]

NAME IN FULL: ANDREW ROBERT GIBBS

22/1/2015

Signature: **Date:**

CURRICULUM VITAE FOR RACHEL KATHERINE JEWKES

Title of study/ Research proposal: **Stepping Stones and Creating Futures Intervention Trial**

Protocol no if applicable: N/A

Designation/ Profession: **Director (Gender and Health Research Unit)**

1. Personal Details

Name	**Rachel Katharine Jewkes**	Tel. no.	
Address	**Gender and Health Research Unit, MRC, Private Bag X385, Pretoria 0001**	Work tel. no.	**012 339 8525**
		Fax no.	**012 339 8582**
		Cell phone no	**0824423655**
		Email	**rjewkes@mrc.ac.za**

2. Academic and professional qualifications

Degree	Field of study	University	Year
MBBS	**Medicine**	**St Thomas' Hospital, University of London**	**1986**
MSc Community Medicine	**Public Health**	**London School of Hygiene & Tropical Medicine, University of London**	**1991**
MFPHM	**Public Health Medicine**	**North Thames Regional Health Authority, London UK**	**1993**
Doctor of Medicine (MD)	**Public Health**	**London School of Hygiene & Tropical Medicine, University of London**	**1994**

3. Professional body registration number if applicable
PLEASE ATTACH COPY:

4. Current personal medical malpractice insurance details [medical and dental practitioners] where applicable

5. Relevant related work experience (brief) and current position

Period	Position	Employer
2001- Present	**Director, Gender and Health Research Unit**	**MRC**
1997 - 2000	**Division Head: CERSA**	**MRC**
1995 - 1996	**Specialist Scientist & Coordinator: CERSA**	**MRC**

6. Participation in research in the last three years (title, protocol number, designation) [If multiple proposals/ studies, only list those with relevance to this application, or in the last year.]

Protocol ID: EC022-9/2012

Protocol title: SHARE: Schools intervention for healthier relationships evaluation

Designation: PI

7. Peer-reviewed publications in the past 3 years

1. Mathews S, Abrahams N, Jewkes R. Exploring Mental Health Adjustment of Children Post Sexual Assault in South Africa. Journal of Child Sexual Abuse 2013; 22:639–657.
2. Jina R, Jewkes R, Hoffman S, Dunkle K, Nduna M, Jama Shai N. (2012) Adverse health outcomes associated with emotional abuse in young rural South African women: a cross-sectional study. Journal of Interpersonal Violence. 27(5):862-80
3. Sikweyiya Y, Jewkes R (2012) Potential Research participants' motivations and perceived risks in research participation: Reflections on the implications of ethics in health research. PLoS One 7(4): e35495. doi:10.1371/journal.pone.0035495
4. Jewkes R, Morrell R, Sikweyiya Y, Dunkle K, Penn-Kekana L. Transactional relationships and sex with a woman in prostitution: prevalence and patterns in a representative sample of South African men. BMC Public Health 2012, 12:325 doi:10.1186/1471-2458-12-325
5. Jewkes R, Nduna M, Jama Shai N, Dunkle D. (2012) Prospective study of rape perpetration by young South African men: incidence & risk factors. PLoS One 7(5), e38210.
6. Sikweyiya Y, Jewkes R 'Why did they want to know if I hit you?' Perceptions and experiences of research participants on gender-based violence community based survey: Implications for ethical guidelines to protect participants. Qualitative Health Research 2013 Jul;23(7):999-1009. Epub 2013 May 9.
7. Jewkes R, Morrell R, Sikweyiya Y, Dunkle K, Penn-Kekana L. (2012) Men, sex and the provider role: Crime, violence, correlated psychological attributes associated with South African men's engagement in prostitution and transactional sex in South Africa. Plos One 7(7): e40821. doi:10.1371/journal.pone.0040821
8. Jama-Shai N, Jewkes R, Nduna M, Dunkle K. Masculinities and condom use patterns among young rural South Africa men: a cross-sectional baseline survey. BMC Public Health 2012, 12:462 doi:10.1186/1471-2458-12-462
9. Jewkes R, Sikweyiya Y, Nduna M, Jama Shai N, Dunkle K Motivations for, and perceptions and experiences of participating in a cluster randomized controlled trial of a HIV behavioural intervention in rural South Africa. Culture Health & Sexuality 2012 Nov;14(10):1167-82. doi: 10.1080/13691058.2012.717305. Epub 2012 Sep 14
10. Gevers A, Jewkes R, Mathews C, Flisher A, "I think it's about experiencing, like, life": A qualitative exploration of contemporary adolescent intimate relationships in South Africa. Culture, Health & Sexuality 2012 Nov;14(10):1125-37. doi: 10.1080/13691058.2012.723752. Epub 2012 Sep 20.
11. Nduna M, Jewkes R. Denied and disputed paternity in teenage pregnancy: Topical Structural Analysis of case studies of young women from the Eastern Cape Province, South Africa. Social Dynamics 2012; 38(2): 314-330.

12. Jewkes R, Dunkle K, Nduna M, Jama-Shai N (2012). Transactional sex and HIV incidence in a cohort of young women in the Stepping Stones trial. Journal of AIDS & Clinical Research 3:158. doi:10.4172/2155-6113.1000158
13. Abrahams N, Jewkes R (2012) Managing and resisting stigma: a qualitative study among people living with HIV in South Africa. Journal of the International AIDS Society 15, 17330. http://dx.doi.org/ 10.7448/IAS.15.2.17330
14. Dartnall E, Jewkes R (2013) Sexual violence against women: the scope of the problem. Best Practice & Research Clinical Obstetrics & Gynaecology 27(1):3-13
15. Abrahams N, Jewkes R, Mathews S. Depressive symptomatology after a sexual assault: Understanding victim-perpetrator relationships and the role of social perceptions. African Journal of Psychiatry 2013;16:288-293.
16. Nduna M, Jewkes R, Colman I. Prevalence and factors associated with depressive symptoms among young women and men in the Eastern Cape, South Africa. Journal of Child and Adolescent Mental Health (in press)
17. Mayosi BM, Lawn JE, van Niekerk A, Bradshaw D, Abdool Karim SS, Coovadia HM; Lancet South Africa team. Health in South Africa: changes and challenges since 2009. Lancet. 2012 Dec 8;380(9858):2029-43. doi: 10.1016/S0140-6736(12)61814-5. Epub 2012 Nov 30.
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20. Dunkle KL, Jewkes R, Murdock DW, Sikweyiya Y, Morrell R Prevalence of consensual male-male sex and sexual violence, and associations with HIV in South Africa: a population-based cross-sectional study. Plos Med 10(6): e1001472. doi:10.1371/journal.pmed.1001472
21. Gevers A, Jewkes R, Mathews C, Cupp P, Russell M Illegal yet developmentally normative: Young, urban adolescents' dating and sexual behaviour in South Africa Illegal yet developmentally normative: Young, urban adolescents' dating and sexual behaviour in South Africa. BMC International Health 2013 Jul 10;13(1):31. [Epub ahead of print]
22. Mathews S, Abrahams N, Jewkes R, Lombard C, Martin L. The Epidemiology of Child Homicides in South Africa Research. World Health Bulletin 2013;91:562–568 | doi: http://dx.doi.org/10.2471/BLT.12.117036
23. Jina R, Jewkes R, Christofides N Knowledge and confidence of South African health care providers regarding post-rape care: a cross-sectional study. BMC Health Services Research 2013, 13:257 doi:10.1186/1472-6963-13-257
24. Jewkes R Intimate partner violence: the end of routine screening. The Lancet 2013; Apr 15. pii: S0140-6736(13)60584-X. doi: 10.1016/S0140-6736(13)60584-X
25. Gevers A, Jewkes R, Mathews C. What do adolescents think makes their relationships good? An exploratory analysis of factors associated with South African adolescents' assessments of their dating relationships. Culture Health and Sexuality 2013;15(9):1011-25. doi: 10.1080/13691058.2013.803295. Epub 2013 Jun 27.
26. Morrell R, Jewkes R, Lindegger G, Hamlall V. (2013) Hegemonic Masculinity: Reviewing the Gendered Analysis of Men's Power in South Africa. South African Review of Sociology 44 (1), 3-21.

27. Russell M, Cupp P, Jewkes R, Gevers A, Mathews C, LeFleur-Bellerose C, Small J. Intimate Partner Violence among Adolescents in Cape Town, South Africa. Prevention Science 2013 Jun 8. [Epub ahead of print]
28. Nduna M, Jewkes R, Dunkle K, Jama-Shai N, Coleman I (2013) Prevalence and factors associated with depressive symptoms among young women and men in the Eastern Cape Province, South Africa Journal of Child and Adolescent Mental Health 25(1), 35-42.
29. Mathews S, Abrahams N, Jewkes R, Martin LJ. (2013) Under-reporting child abuse deaths: experiences from a national study on child homicide. S Afr Med J. Mar;103(3):132-3.
30. Jewkes R, Fulu E, Roselli T, Garcia-Moreno C (2013) Prevalence and risk factors for non-partner rape perpetration: findings from the UN Multi-country Cross-sectional Study on Men and Violence in Asia and the Pacific. The Lancet Global Health Published online September 10, 2013 http://dx.doi.org/10.1016/S2214-109X(13)70069-X e1
31. Fulu E, Jewkes R, Roselli T, Garcia-Moreno C (2013) Prevalence and risk factors for male perpetration of intimate partner violence: findings from the UN Multi-country Cross-sectional Study on Men and Violence in Asia and the Pacific. The Lancet Global Health Published online September 10, 2013 http://dx.doi.org/10.1016/S2214-109X(13)70074-3
32. Christofides N, Jewkes R, Dunkle K, Nduna M, Jama-Shai N, Sterk C. Early pregnancy increases risk of incident HIV infection in the Eastern Cape, South Africa: a prospective study. Journal of the International AIDS Society. 2014 Mar 19;17(1):18585. doi: 10.7448/IAS.17.1.18585. eCollection 2014.
33. Gibbs A, Sikweyiya Y, Jewkes R. (2014) "Men value their dignity": securing respect and identity construction in urban informal settlements in South Africa. Global Health Action 7, 23676.
34. Gibbs A, Jewkes R, Mbatha N, Washington L, Willan S. (2014) Jobs, food, taxis and journals: complexities of implementing Stepping Stones and Creating Futures in urban informal settlements in South Africa. AJAR 13(2):161-7. doi: 10.2989/16085906.2014.927777.
35. Gibbs, Jewkes R, Sikweyiya Y, Willan S. (2014) Reconstructing Masculinity? A qualitative evaluation of the Stepping Stones and Creating Futures intervention in urban informal settlements in South Africa. Culture, Health & Sexuality http://dx.doi.org/10.1080/13691058.2014.966150.
36. Christofides NJ, Jewkes RK, Dunkle KL, McCarty F, Jama Shai N, Nduna M, Sterk CE. (2014) Risk factors for unplanned and unwanted teenage pregnancies over two years of follow up among a cohort of young South African women Global Health Action 7:23719 http://dx.doi.org/10.3402/gha.v7.23719
37. Christofides N, Jewkes R, Dunkle K, Nduna M, Jama-Shai N. (2014) Perpetration of physical and sexual abuse and subsequent fathering of pregnancies among a cohort of young South African men. BMC Public Health 14:947. doi: 10.1186/1471-2458-14-947.
38. Jewkes R, Sikweyiya Y, Jama-Shai N (2014) The challenges of research on violence in post-conflict Bougainville. The Lancet June 10, 2014 http://dx.doi.org/10.1016/S0140-6736(14)60969-7
39. Jewkes R, Gibbs A, Jama-Shai N, Willan S, Misselhorn S, Mushinga M, Washington L, Mbatha N, Sikweyiya Y. (2014) Stepping Stones and Creating Futures Intervention: Outcomes of a shortened interrupted time series evaluation of

behavioural and structural intervention for young people in informal settlements in Durban, South Africa BMC Public Health 1325: DOI 10.1186/1471-2458-14-1325
40. Sikweyiya Y, Dunkle K, Jewkes R (2014) Impact of HIV on and the constructions of masculinities among HIV positive men in South Africa: Implications for secondary prevention programs. Global Health Action **7**: 24631 - http://dx.doi.org/10.3402/gha.v7.24631
41. Jewkes R, Flood M, Lang J (2014) From working with men and boys to changing social norms and reducing inequities in gender relations: a paradigm shift in prevention of violence against women and girls. The Lancet http://dx.doi.org/10.1016/ S0140-6736(14)61683-4
42. Mathews S, Jewkes R, Abrahams N. (2014) "So now I'm the man": Intimate partner femicide and its interconnections with expressions of masculinities in South Africa. British Journal of Criminology. doi:10.1093/bjc/azu076
43. Jewkes R (2014) (How) Can we reduce gender-based violence by 50% over the next 30 years? Plos Medicine 11(11): e1001761. doi:10.1371/journal.pmed.1001761
44. Jewkes R. (2015) SHARE: a milestone in joint programming for HIV and intimate partner violence. The Lancet Global Health vol 3 http://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X(14)70374-2.pdf
45. Jina R, Jewkes R, Vetten L, Christofides N, Sigsworth R, Loots L (in press) Genito-anal injury patterns and associated factors in rape survivors in an urban province of South Africa: a cross-sectional study. BMC Public Health

8. Any additional relevant information supporting abilities to participate in conducting this trial. [Briefly]

Honors

- **NRF Rating 2011 A2**
- **Acting MRC President December 2012-January 2013**
- **Acting Vice-President (Research Support) February2013– September 2014**
- Millenium Health Award. International award to support cooperation in health research for development. Rockefeller Foundation, 2000.
- Polgar prize, professional prize for the best paper published in Medical Anthropology Quarterly in 2008 for paper "Showing Roughness in a Beautiful Way": Talk about Love, Coercion, and Rape in South African Youth Sexual Culture.
- Appointed by the Director General of the World Health Organisation as a member of the WHO Expert Advisory Panel on Injury and Violence Prevention and Control from 1 June 2010 for four years. Renewed in 2014.
- Appointed by PEPFAR to their Scientific Advisory Board, established in 2010.
- Appointed as a member of WHO's Strategic and Technical Advisory Committee for HIV-AIDS (STAC-HIV) for the period 2011 – 2012
- 2014 Thomsons Reuters World's Most Highly Influential Scientific Minds list
- 2014 awarded Gold Medal by the Medical Research Council of South Africa
- Secretary of the Sexual Violence Research Initiative from 2006- present, this is a global initiative to promote evidence based action to end sexual violence

- Appointed as a member of WHO's Strategic and Technical Advisory Committee for HIV-AIDS (STAC-HIV) for the period 2011 – present
- Steering Group, WHO guidelines on the health sector response to partner violence and sexual violence. 2010-2013
- Member of the Expert Group on Intimate Partner Violence, Childhood Sexual Abuse and Non-partner Sexual Violence, Global Burden of Disease Study 2008-12
- Steering Committee Member for the WHO Multi-Country Study on Domestic Violence Against Women. From 1998 - 2006

NAME IN FULL: RACHEL KATHARINE JEWKES

22/1/2015

Signature: **Date:**

CURRICULUM VITAE FOR ESNAT DOROTHY CHIRWA

Title of study/ Research proposal: **Stepping Stones and Creating Futures Intervention Trial**

Protocol no if applicable: N/A

Designation/ Profession: **Senior Statistician, Gender & Health Research Unit**

1. Personal Details

NAME			
ADDRESS	**Gender and Health Research Unit, MRC, Private Bag X385, Pretoria 0001**	Work tel. no.	**012 339 8556**
		Fax no.	**012 339 8582**
		Cell phone no	**072 119 3527**
		Email	**Esnat.Chirwa@mrc.ac.za**

2. Academic and professional qualifications

Degree	Field of study	University	Year
BSc	**Statistics and Computer Science**	**University of Malawi**	**1994**
Post-grad. Diploma	**Statistics**	**University of Reading, UK**	**2001**
MSc	**Biometry**	**University of Reading, UK**	**2002**

3. Professional body registration number if applicable
PLEASE ATTACH COPY: N/A

4. Current personal medical malpractice insurance details [medical and dental practitioners] where applicable

5. Relevant related work experience (brief) and current position

Period	Position	Employer
2014- present	**Senior Statistician**	**MRC**
2010-2014	**PhD student/ Faculty Biostatistics Tutor**	**University Witwatersrand**
2004-2013	**Lecturer**	**University of Malawi**
1994-1998	**High School Maths Teacher**	**Mulunguzi Sec Sch.**

6. Participation in research in the last three years (title, protocol number, designation) [If multiple proposals/ studies, only list those with relevance to this application, or in the last year.]

7. Peer-reviewed publications in the past 3 years

1. Gradidge PJ, Crowther NJ, **Chirwa ED**, Norris SA, Micklesfield LS: Patterns, levels and correlates of self-reported physical activity in urban black Soweto women. **BMC Public Health** 2014, **14**:934 doi:10.1186/1471-2458-14-934

2. **Chirwa E.D**, Griffiths PL, Maleta K, Ashorn P, Pettifor J.M, Norris S.A. Postnatal growth velocity and overweight in early adolescents: A comparison of rural and urban African boys and girls. *American Journal of Human Biology. 2014 Jun; 26(5): 643-651.*
3. **Chirwa ED**, Griffiths PL, Maleta K, Norris SA, Cameron N. Multi-level modelling of longitudinal child growth data from the Birth-to-Twenty Cohort: a comparison of growth models. *Annals of Human Biology. 2014 Mar; 41(2):166-177.*
4. Chirwa T.F., Nyasulu P.S., **Chirwa E.D.**, Ketlogetswe A., Bello G.A., Dambe I., Ndalama D., Joshua M.C. Treatment adherence levels in the intensive and continuation phases among pulmonary TB patients from Zomba Central Hospital, Malawi, 2007-8. *PLOS One 8(5): e63050. doi:10.1371/journal.pone.006305*

8. Any additional relevant information supporting abilities to participate in conducting this trial. [Briefly]

HONOURS AND AWARDS

NAME IN FULL: Esnat Dorothy Chirwa

Signature: **Date:** **23-01-2014**

CURRICULUM VITAE FOR NWABISA JAMA SHAI

Title of study/ Research proposal: **Stepping Stones and Creating Futures Intervention Trial**

Protocol no if applicable: N/A

Designation/ Profession:

1. Personal Details

Name	**Nwabisa Jama Shai**	Tel. no.	**012 3398528**
Address	**1 Soutpansberg Rd**	Work tel. no.	**012 3398528**
	Pretoria	Fax no.	**012 3398582**
		Cell phone no	**0719003651**
		Email	**nshai@mrc.ac.za**

2. Academic and professional qualifications

Degree	Field of study	University	Year
Masters in Public Health	**Public Health**	**Western Cape**	**2006**
Diploma in Public Health	**Public Health**	**Western Cape**	**2004**

3. Professional body registration number if applicable
PLEASE ATTACH COPY: N/A

4. Current personal medical malpractice insurance details [medical and dental practitioners] where applicable

5. Relevant related work experience (brief) and current position

Period	Position	Employer
Jan 2011- present	**Senior Scientist**	**Medical Research Council**
Aug 2012 - present	**Honorary Lecturer**	**University of the Witwatersrand**
Jul 2009-Jul 2010	**Research Manager**	**Gender Links**
Apr 2005-Jun 2007	**Scientist**	**Medical Research Council**

6. Participation in research in the last three years (title, protocol number, designation) [If multiple proposals/ studies, only list those with relevance to this application, or in the last year.]

None.

7. Peer-reviewed publications in the past 3 years

1. Jina R, Jewkes R, Hoffman S, Dunkle K, Nduna M, Jama Shai N. (2012) Adverse health outcomes associated with emotional abuse in young rural South African women: a cross-sectional study. Journal of Interpersonal Violence. 27(5):862-80
2. Jewkes R, Nduna M, Jama Shai N, Dunkle D. (2012) Prospective study of rape perpetration by young South African men: incidence & risk factors. PLoS One 7(5), e38210.

3. Jama-Shai N, Jewkes R, Nduna M, Dunkle K. Masculinities and condom use patterns among young rural South Africa men: a cross-sectional baseline survey. BMC Public Health 2012, 12:462 doi:10.1186/1471-2458-12-462
4. Jewkes R, Sikweyiya Y, Nduna M, Jama Shai N, Dunkle K Motivations for, and perceptions and experiences of participating in a cluster randomized controlled trial of a HIV behavioural intervention in rural South Africa. Culture Health & Sexuality 2012 Nov;14(10):1167-82. doi: 10.1080/13691058.2012.717305. Epub 2012 Sep 14
5. Jewkes R, Dunkle K, Nduna M, Jama-Shai N (2012). Transactional sex and HIV incidence in a cohort of young women in the Stepping Stones trial. Journal of AIDS & Clinical Research 3:158. doi:10.4172/2155-6113.1000158
6. Nduna M, Jewkes R, Dunkle K, Jama-Shai N, Coleman I (2013) Prevalence and factors associated with depressive symptoms among young women and men in the Eastern Cape Province, South Africa Journal of Child and Adolescent Mental Health 25(1), 35-42.
7. Christofides N, Jewkes R, Dunkle K, Nduna M, Jama-Shai N, Sterk C. Early pregnancy increases risk of incident HIV infection in the Eastern Cape, South Africa: a prospective study. Journal of the International AIDS Society. 2014 Mar 19;17(1):18585. doi: 10.7448/IAS.17.1.18585. eCollection 2014.
8. Christofides NJ, Jewkes RK, Dunkle KL, McCarty F, Jama Shai N, Nduna M, Sterk CE. (2014) Risk factors for unplanned and unwanted teenage pregnancies over two years of follow up among a cohort of young South African women Global Health Action 7:23719 http://dx.doi.org/10.3402/gha.v7.23719
9. Christofides N, Jewkes R, Dunkle K, Nduna M, Jama-Shai N. (2014) Perpetration of physical and sexual abuse and subsequent fathering of pregnancies among a cohort of young South African men. BMC Public Health 14:947. doi: 10.1186/1471-2458-14-947.
10. Jewkes R, Sikweyiya Y, Jama-Shai N (2014) The challenges of research on violence in post-conflict Bougainville. The Lancet June 10, 2014 http://dx.doi.org/10.1016/S0140-6736(14)60969-7
11. Jewkes R, Gibbs A, Jama-Shai N, Willan S, Misselhorn S, Mushinga M, Washington L, Mbatha N, Sikweyiya Y. (2014) Stepping Stones and Creating Futures Intervention: Outcomes of a shortened interrupted time series evaluation of behavioural and structural intervention for young people in informal settlements in Durban, South Africa BMC Public Health 1325: DOI 10.1186/1471-2458-14-1325

8. Any additional relevant information supporting abilities to participate in conducting this trial. [Briefly]

NAME IN FULL: Nwabisa Jama-Shai

_____ 23 Jan 2015

Signature: **Date**

CURRICULUM VITAE FOR Samantha Donna Willan

Title of study/ Research proposal: Stepping Stones and Creating Futures Intervention Trial

Protocol no if applicable: N/A

Designation/ Profession: Program Manager, Gender Equality & Health; Health Economics and HIV/AIDS Research Division (HEARD), University of KwaZulu-Natal, South Africa

1. Personal Details

Name	**Samantha Donna Willan**		
Address	**HEARD, University of KwaZulu-Natal, Westville Campus, J Block, Durban, 4041, South Africa**	Work tel. no.	**031 2602592**
		Cell phone no	**079 595 3680**
		Email	**Samantha.willan@gmail.com**

2. Academic and professional qualifications

Degree	Field of study	University	Year
Bachelor of Arts	Political Science & Labour Studies	University of Natal, South Africa	1994
Bachelor of Arts Honors	Political Science	University of Natal, South Africa	1995
Master of Arts	Political Science	University of Natal, South Africa	1999

3. Professional body registration number if applicable N/A
PLEASE ATTACH COPY:

4. Current personal medical malpractice insurance details [medical and dental practitioners] where applicable N/A

5. Relevant related work experience (brief) and current position

Period	Position	Employer
2010 – present	Programme Manager, Gender Equality & Health, HEARD	University of KwaZulu-Natal, SA
2007-2010	Independent Consultant – HIV, Sexuality and Gender Equality	Self employed
2004-2006	Policy Advisor – Gender & HIV	VSO, UK
2000- 2004	Operations Manager, HEARD	University of KwaZulu-Natal
1998-2000	Researcher, Natal University Development Foundation	University of Natal
1996-1998	Information Manager	Truth & Reconciliation Commission, South Africa

6. Participation in research in the last three years (title, protocol number, designation) [If multiple proposals/ studies, only list those with relevance to this application, or in the last year.]

Protocol ID: N/A
Protocol title: A two-pronged service and community mobilisation intervention to reduce gender-based violence and HIV vulnerability in rural South Africa. Canadian Institute for Health Research (CIHR), 2011-2016
Designation: Co-Investigator

Protocol ID: N/A
Protocol title: Sexual & reproductive health and rights of young people living with HIV
Designation: Co-PI

Protocol ID: N/A
Protocol title: The development and evaluation of gender transformative and livelihood strengthening intervention to reduce IPV in urban informal settlements, South Africa
Designation: Co-PI

7. Peer-reviewed publications in the past 3 years

- Jewkes, R, Gibbs, A, Jama-Shai, N, Willan, S, Misselhorn, A, Mushinga, M, Washington, L, Mbatha, N, Skiweyiya, Y. (2014) Stepping Stones and Creating Futures Intervention: shortened interrupted time series evaluation of a behavioural and structural health promotion and violence prevention intervention for young people in informal settlements in Durban, South Africa, *BMC Public Health*
- Gibbs, A, Jewkes, R, Sikweyiya, Y, & Willan, S. (2015) Reconstructing masculinity? A qualitative evaluation of the Stepping Stones and Creating Futures interventions in urban informal settlements in South Africa, *Culture, Health and Sexuality* 17:2, 208-222
- Gibbs, A, Jewkes, R, Mbatha, N, Washington, L & Willan, S (2014) Jobs, food, taxis and journals: Complexities of implementing Stepping Stones and Creating Futures in urban informal settlements in South Africa, *African Journal of AIDS Research*, 13:2, 161-167, DOI: 10.2989/16085906.2014.927777
- Gibbs, A., Mushinga, M., Crone, E., Willan, S. & Mannell, J. (2012*) How do national strategic plans for HIV and AIDS in Southern and Eastern Africa address gender-based violence? A women's rights perspective*. Health and Human Rights
- Gibbs, A, Willan, S, Misselhorn, A & Mangoma J (2012) *Combined structural interventions for gender equality and livelihood security: a critical review of the evidence from southern and eastern Africa and the implications for young people,* Journal of the International AIDS Society 2012, 15(Suppl 1)
- Gibbs, A., Crone, E.T., **Willan, S**. & Mannell, J. (2012) *The inclusion of women, girls and gender equality in National Strategic Plans for HIV and AIDS in southern and eastern Africa*. Global Public Health

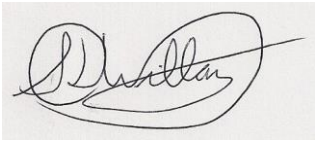
8. Any additional relevant information supporting abilities to participate in conducting this trial. [Briefly]

I was a core team member in the conceptualization, development and evaluation of the Stepping Stones and Creating Futures pilot study, building young women's and men's

livelihoods, while transforming gender norms, as a pathway to reduce VAWG. I am also Co-PI of a UNAIDS Global study developing and providing in-country technical support to pilot an Implementation Framework to reduce GBV and HIV.

My contribution to the proposed study will include involvement in planning the project, ongoing oversight and management of the research and evaluation component, supporting development of research tools, qualitative data analysis and writing of the research findings.

NAME IN FULL: Samantha Donna Willan



Signature: 22 Janaury 2015 **Date:**

CURRICULUM VITAE FOR YANDISA MSIMELELO SIKWEYIYA

Title of study/ Research proposal: Stepping Stones and Creating Futures Intervention Trial

Protocol no if applicable: N/A

Designation/ Profession: Specialist Scientist, Gender & Health Research Unit

1. Personal Details

NAME			
ADDRESS	**Gender and Health Research Unit, MRC, Private Bag X385, Pretoria 0001**	Work tel. no.	**012 339 8619**
		Fax no.	**012 339 8582**
		Cell phone no	**076 365 6169**
		Email	**ysikweyiya@mrc.ac.za**

2. Academic and professional qualifications

Degree	Field of study	University	Year
BSc	**Health Promotion**	**University of Transkei**	**2000**
Post-grad. Diploma	**Health Promotion**	**University of Transkei**	**2002**
MSc	**Public Health**	**Umea University, Sweden**	**2005**
Post-graduate Certificate	**Research Ethics**	**University of Pretoria & University of KwaZulu-Natal**	**2006**
PhD	**Public Health**	**University of the Witwatersrand**	**2013**

3. Professional body registration number if applicable
PLEASE ATTACH COPY:

4. Current personal medical malpractice insurance details [medical and dental practitioners] where applicable

5. Relevant related work experience (brief) and current position

Period	Position	Employer
2013-present	**Specialist Scientist**	**MRC**
2010- 2012	**Senior Scientist**	**MRC**
2008-2009	**Scientist**	**MRC**
2002-2007	**Senior Research Technologist**	**MRC**

6. Participation in research in the last three years (title, protocol number, designation) [If multiple proposals/ studies, only list those with relevance to this application, or in the last year.]

Protocol title: The development and evaluation of gender transformative and livelihood strengthening intervention to reduce IPV in urban informal settlements, South Africa.

Designation: Co-investigator

7. Peer-reviewed publications in the past 3 years

1. Jewkes R, Gibbs A, Jama-Shai N, Willan S, Misselhorn A, Mushinga L, Mbatha N, **Sikweyiya Y**. Stepping Stones and Creating Futures Intervention: shortened interrupted time series evaluation of a structural health promotion and violence prevention intervention for young people in informal settlements in Durban South Africa. BioMedical Central, Public Health, 2014, 14:1325.

2. Baholo M, Christofides N.J, Wright A, **Sikweyiya Y**, Jama Shai N. Women's experiences leaving abusive relationships – A shelter-based qualitative study. Culture, Health & Sexuality, 2014.

3. Nkosi S, **Sikweyiya Y,** Kekwaletswe C, Morojele N. Male circumcision, alcohol use, and unprotected sex among patrons of bars and taverns in rural areas of North West province, South Africa. AIDS Care, 2014.

4. Gibbs A, Jewkes R, **Sikweyiya Y,** Willan S. Reconstructing Masculinity? A qualitative evaluation of the Stepping Stones and Creating Futures intervention in urban informal settlements in South Africa. Culture, Health & Sexuality, 2014.

5. **Sikweyiya Y,** Jewkes R, Dunkle K. Impact of HIV on and constructions of masculinities among HIV positive men in South Africa: Implications for secondary prevention programs. Global Health Action, 2014, 7: 24631

6. Jewkes R, **Sikweyiya Y,** Jama Shai N. The challenges of research on violence in post-conflict Bougainville. Lancet, 2014, 383, 2038-2039

7. Gibbs A, **Sikweyiya Y,** Jewkes R. 'Men value their dignity': securing respect and identity construction in urban informal settlements in South Africa. Global Health Action, 2014, 7: 23676

8. Dunkle K.L, Jewkes R.K, Murdock D.W, **Sikweyiya Y,** Morrell R. Prevalence of consensual male-male sex and sexual violence, and associations with HIV in South Africa: A population based cross-sectional study. Plos Medicine, 2013, 10(6): e1001472. DOI: 10.1371/journal.pmed.100147

9. Gevers A, Jama-Shai N, **Sikweyiya Y.** Gender-based violence and the need for evidence-based primary prevention in South Africa. African Safety Promotion Journal, 2013, 11(2), 14-20

10. Nduna M, **Sikweyiya Y.** Silence in Young Women's Narratives of Absent and Unknown Fathers from Mpumalanga Province, South Africa. J Child Fam Stud. 2013, 22(8). DOI 10.1007/s10826-013-9866-3

11. **Sikweyiya Y,** Jewkes R. Potential Motivations For and Perceived Risks In Research Participation: Ethics in Health Research. Qualitative Health Research, 2013, 23(7), 999-1009

12. **Sikweyiya Y,** Jewkes R, Dartnall E. Men's perspectives on participating in violence against women perpetration research. Agenda, 2013, 27(1), 40-48

13. Jewkes R, Morrell R, **Sikweyiya Y,** Penn-Kekana L. Transactional relationships and sex with a woman in prostitution: prevalence and patters in a representative sample of South African Men. BMC Public Health, 2012, 12: 325

14. Jewkes R, Morrell R, **Sikweyiya Y,** Dunkle K, Penn-Kekana L. Men, Prostitution and the Provider Role: Understanding the Intersections of Economic Exchange, Sex, Crime and Violence in South Africa. PLoS ONE, 2012, 7(7): e40821. doi:10.1371/journal.pone.0040821

15. **Sikweyiya Y,** Jewkes R. Perceptions and Experiences of Research Participants on Gender-based Violence Community based Survey: Implications for ethical guidelines. PLoS ONE, 2012, 7(4), 1-9
16. Jewkes R, **Sikweyiya Y,** Nduna M, Jama Shai N, Dunkle K. Motivations for, and perceptions and experiences of participating in a cluster randomized controlled trial of a HIV behavioural intervention in rural South Africa. Culture, Health and Sexuality, 2012, 14(10), 1167-1182

8. Any additional relevant information supporting abilities to participate in conducting this trial. [Briefly]

HONOURS AND AWARDS

2014 Featured in the South African Public Sector Magazine May 2014 edition.

2012 Selected as one of the Mail and Guardian top 200 young South Africans

2011 Best Poster award for research under the age of 40, Sexual Violence Research Initiative

2006: Best Poster award for Researcher less than 40 years old, Global Forum for Health Research

NAME IN FULL: Yandisa Msimelelo Sikweyiya

_____ 22-01-2014_____

Signature: **Date:**

CURRICULUM VITAE FOR LAURA WASHINGTON

Title of study/ Research proposal: Stepping Stones and Creating Futures Intervention Trial

Protocol no if applicable: N/A

Designation/ Profession: Director, Project Empower

1. Personal Details

NAME			
ADDRESS	**W218 Diakonia Centre, 20 Diakonia Avenue, Durban**	Work tel. no.	**031 3103565**
		Fax no.	**031 3103566**
		Cell phone no	**083 303 8953**
		Email	**laura@projectempower.org.za**

2. Academic and professional qualifications

Degree	Field of study	University	Year
BA	**English History**	**University of Natal**	**1982**
Post-grad. Diploma	**Education**	**University of Natal**	**1984**
M. Sc	**Development Studies**	**University of Natal**	**ongoing**

3. Professional body registration number if applicable
PLEASE ATTACH COPY:

4. Current personal medical malpractice insurance details [medical and dental practitioners] where applicable

5. Relevant related work experience (brief) and current position

Period	Position	Employer
2013- present	**Director**	**Project Empower**
2002 - 2012	**Programmes Manager**	**Project Empower**
1982 - 2001	**Consultant**	**A range of NGOs**

6. Participation in research in the last three years (title, protocol number, designation) [If multiple proposals/ studies, only list those with relevance to this application, or in the last year.]

Joint Gender Fund, South Africa (No Number) Project Empower (PIs) 01/01/2012-30/12/2014
Mbokodo Project

A project aimed at raising consciousness of women and developing women's leadership in addressing domestic and other forms of gender based violence in the rural setting.

Oxfam Australia **Project Empower (PIs)**
2012-/2014
Mkabayi Project
This project works with young women in urban informal settlements where people in general and women in particular are politically, economically and socially marginalized to encourage and enable access to a range of rights assured to them in the Constitution

Completed Research Support
Sida/UKZN: 51040023 **Gibbs (PI)**
01/06/2013-01/06/2014
Young women and social grants: issues of access and impact
Swedish International Development Agency (SIDA), Institutional Grant to HEARD, UKZN
The goal of this qualitative exploratory work is to work with 45 young women (18-25) in urban informal settlements who are eligible for the child support grant and either accessing or not, to understand both the difficulties they face in accessing social grants and how they use social grants in their lives. This work provides a foundation for development of an intervention around this.
Role: Co-I

Canadian International Development Agency **Project Empower**
2012-2013
Access to SRHR for young women in informal settlements and addressing IPV
The project looked at the importance of knowledge and access to sexual and reproductive health rights for young women in urban informal settlements in understanding their own sexuality, sexual urgency, gender inequality and reducing incidences of HIV primary infection. It further used this awareness around rights as means to addressing intimate partner violence, especially sexual violence, amongst young couples.

Action Aid (No Number) **Project Empower (PIs)**
2/2008 – 12/2008
Gender and HIV Capacity
The project was a test project for the Action Aid's STaR approach in urban communities. The project looked at the interface of Gender and HIV and Rights and using this understanding of this interface and the impact it has on communities to mobilise communities and advocate for better services.

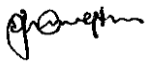
Joint HIV/AIDS Programme (JOHAP), Oxfam **Project Empower (PIs)**
6/2008 -6/2009
Gender and gender based violence with young men in urban informal settlements
This project worked with young men in informal settlements to explore and understand gender and how it impacts on their lives. It aimed to help young men break the societal pressures of masculinity and challenged how these imposed ideals of masculinity played on and impacted the quality of relationships that they enjoyed with the intimate partners and community as a whole.

7. Peer-reviewed publications in the past 3 years

1. O'Reilly, M. & **Washington, L**. (2012) Young women from informal settlements report on their experiences of accessing sexual and reproductive and other health services from clinics. *Agenda*, Vol. 26, No.2 pages 126-138
2. Misselhorn, A., Mushinga, M., Jama-Shai, N. & **Washington, L**. (2014) Creating Futures: lessons from the development of a livelihood strengthening curriculum for young people in eThekwini's informal settlements. *Sex Education*, 14(5), 543-555
3. Gibbs, A., Jewkes, R., Willan, S., **Washington, L**., Mbatha, N. (2014) Jobs, food, taxis and journals: complexities of implementing a structural and behavioural intervention in urban South Africa. *AJAR*, 13:2, 161-167
4. Misselhorn, A, Jama Shai N, Mushinga M, **Washington L**, Mbatha N (2013) Creating Futures: Supporting young people in building their livelihoods. Manual. http://www.heard.org.za/gender/creating-futures-stepping-stones
5. Project Empower (**Washington, L** & Mbatha, N.) Building Positive Organisations through Policy Development: Learning from Project Empower's Experiences. Oxfam Australia: Durban. http://www.oxfam.de/sites/www.oxfam.de/files/building_positive_organisations_through_policy_development.pdf

8. Any additional relevant information supporting abilities to participate in conducting this trial. [Briefly]

NAME IN FULL: Laura Washington



23-01-2014

Signature: **Date:**

15.0 References

1. WHO. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva: WHO, 2013.
2. Seedat M, Van Niekerk A, Jewkes R, Suffla S, Ratele K. Health in South Africa 5 Violence and injuries in South Africa: prioritising an agenda for prevention. Lancet. 2009;374(9694):1011-22. doi: Doi 10.1016/S0140-6736(09)60948-X. PubMed PMID: ISI:000270154100032.
3. Seedat M, Van Niekerk A, Jewkes R, Suffla S, Ratele K. Violence and injuries in South Africa: prioritising an agenda for prevention. The Lancet. 2009;374:1011-22.
4. Machisa M, Jewkes R, Lowe-Morna C, Rama K. The war at home. . Johannesburg: GenderLinks; 2011.
5. Jewkes R, Sikweyiya Y, Morrell R, Dunkle K. Understanding men's health and use of violence: interface of rape and HIV in South Africa. Pretoria: Medical Research Council, 2008.
6. Jewkes R, Sikweyiya Y, Morrell R, Dunkle K. Gender inequitable masculinity and sexual entitlement in rape perpetration South Africa: findings of a cross-sectional study PloS One. 2011;6(12). doi: 10.1371/journal.pone.0029590.
7. WHO, UN-Habitat. Hidden Cities: Unmasking and overcoming health inequities in urban settings. Geneva: WHO and UN-Habitat, 2010.
8. Thomas L, Vearey J, Mahlangu P. Making a difference to health in slums: an HIV and African perspective. Lancet. 2011;377(9777):1571-2.
9. Greif MJ, Nii-Amoo Dodoo F, Jayaraman A. Urbanisation, Poverty and Sexual Behaviour : The Tale of Five African Cities. Urban Studies. 2011;48(5):947–57.
10. WHO. Our Cities, Our Health, Our Future: Acting on social determinants for health equity in urban settings. Geneva: WHO, 2008.
11. Rehle T, Shisana O, Pillay V, Zuma K, Puren A, Parker W. National HIV incidence measures - new insights into the South African epidemic. Samj S Afr Med J. 2007;97(3):194-9. PubMed PMID: ISI:000245419000021.
12. Shisana O, Rehle T, Simbayi LC, Zuma K, Jooste S, Zungu N, et al. South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town: HSRC Press, 2014.
13. Jewkes R, Gibbs A, Jama-Shai N, Willan S, Misselhorn A, Mbatha N, et al. Stepping Stones and Creating Futures intervention: shortened interrupted time series evaluation of a behavioural and structural health promotion and violence prevention intervention for young people in informal settlements in Durban, South Africa. BMC Public Health. 2014;(14):1325. doi: 10.1186/1471-2458-14-1325.
14. Hunter M. Love in the Time of AIDS: Inequality, Gender, and Rights in South Africa. Durban: University of KwaZulu-Natal Press; 2010.
15. Kamndaya M, Thomas L, Vearey J, Sartorius B, Kazembe L. Material Deprivation Affects High Sexual Risk Behavior among Young People in Urban Slums, South Africa. Journal of Urban Health. 2014. doi: 10.1007/s11524-013-9856-1.
16. Crush J, Drimie S, Frayne B, Caeser M. The HIVand urban food security nexus in Africa. Food Security. 2011;3:347–62.
17. Mmari K, Blum R, Sonenstein F, Marshall B, Brahmbhatt H, Venables E, et al. Adolescents' perceptions of health from disadvantaged urban communities: Findings from the WAVE study. Social Science & Medicine. 2014;104(0):124-32. doi: http://dx.doi.org/10.1016/j.socscimed.2013.12.012.

18. Jewkes R, Morrell R. Gender and sexuality: emerging perspectives from the heterosexual epidemic in South Africa and implications for HIV risk and prevention. J Int AIDS Soc. 2010;13:6. Epub 2010/02/26. doi: 10.1186/1758-2652-13-6. PubMed PMID: 20181124; PubMed Central PMCID: PMC2828994.
19. Silberschmidt M. Disempowerment of men in rural and urban East Africa: Implications for male identity and sexual behavior. World Dev. 2001;29(4):657-71. PubMed PMID: ISI:000168358700006.
20. Gibbs A, Jewkes R, Sikweyiya Y, Willan S. Reconstructing Masculinity? A qualitative evaluation of the Stepping Stones and Creating Futures intervention in urban informal settlements in South Africa Cult Health Sex. 2015.
21. Gibbs A, Willan S, Misselhorn A, Mangoma J. Combined structural interventions for gender equality and livelihood security: a critical review of the evidence from southern and eastern Africa and the implications for young people. Journal of the International AIDS Society. 2012;15(Supp. 1):17362.
22. Jewkes R, Nduna M, Levin J, Jama N, Dunkle K, Puren A, et al. Impact of Stepping Stones on incidence of HIV, HSV-2 and sexual behaviour in rural South Africa: cluster randomised controlled trial. *British Medical Journal* 2008;337:a506.
23. Jewkes R. Intimate partner violence: causes and prevention. Lancet. 2002;359(9315):1423-9. Epub 2002/04/30. doi: S0140-6736(02)08357-5 [pii] 10.1016/S0140-6736(02)08357-5. PubMed PMID: 11978358.
24. Gibbs A, Sikweyiya Y, Jewkes R. “Men value their dignity”: securing respect and identity construction in urban informal settlements in South Africa. Global Health Action. 2014;7(1):1-10.
25. Connell R. Gender and power: Society, the Person and Sexual Politics. . Palo Alta, Calif.: University of California Press; 1987.
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16.0 Appendices

Please find separately attached:

- Appendix 1: Male Baseline Quantitative Questionnaire
- Appendix 2: Female Baseline Quantitative Questionnaire
- Appendix 3: Male 12 and 24 month Quantitative Questionnaire
- Appendix 4: Female 12 and 24 Month Quantitative Questionnaire
- Appendix 5: Confidentiality Agreement
- Appendix 6: Information Sheet and Informed Consent
- Appendix 7: Gatekeeper Letter