Evaluating a Workshop on Gender-Based Violence Prevention and Bystander Intervention

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Abstract

The purpose of this evaluation was to assess whether an online workshop on gender-based violence prevention and bystander intervention at a South African university (1) increased the participants' confidence to discuss gender-based violence (GBV) acts with their peers, (2) increased the participants' understanding of the link between GBV and HIV, (3) increased the participants' knowledge of the support structures available on campus, and (4) improved the participants' ability to intervene in violent situations. A differences-in-differences research design was used. The research design consisted of two phases in which participants from four university residences were used as control and intervention groups. The results showed that the participants generally had a strong confidence regardless of the intervention and were able to identify the acts of GBV. They also showed a good understanding of the link between GBV and HIV. The results also indicated that the participants became knowledgeable about the support structures available on campus and that they felt empowered to intervene in violent situations. However, the timing between the different phases and steps (for example the pretest, intervention and post-test) of the research process for both intervention and control groups was too short. The evaluators recommend that more time between follow-up periods be granted to participants in the future in order to examine whether there would be significant changes in the results.

Keywords: bystander; evaluation; gender-based violence; sexual violence; online workshop

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Introduction and Background Information

Even though the rate of gender-based violence (GBV) is alarmingly high in South Africa, there has been no national survey conducted on campus regarding GBV at universities. Reports on crime statistics specific to national universities are also not available in this country, yet GBV is a public health and human rights problem with devastating effects. Therefore, the magnitude and types of GBV experienced by students at South African universities are not known. In their study on sexual violence in university residences, Duma et al. 2014, 6) report that the attitudes and behaviours of students that increase the risk for sexual violence are also not known. Therefore, this makes it difficult to develop GBV prevention programmes that are specific and applicable to the university environment to reduce the incidences and consequences of GBV or to eradicate them completely within the university space. Sexual violence is categorised as a form of GBV, and research conducted in the United States of America about successful sexual violence prevention programmes highlights some key components that make such programmes comprehensive (Giovanelli and Jackson 2012, 267).

It is reported that a successful sexual violence prevention programme would be one that increases knowledge regarding sexual violence across both genders, demonstrates maintained gains in attitude changes, increases feelings of efficacy in the ability to change situational variables that may contribute to fear and crime, and requires a low time commitment (Giovanelli and Jackson 2012, 267). A prevention initiative implemented at a university in South Africa would need to consider these recommendations to deliver a comprehensive and effective programme.

The bystander approach has been widely researched in the United States of America as a mechanism to prevent sexual violence on many college campuses (Banyard, Plante, and Moynihan 2007, 464). The research states that this approach involves teaching bystanders how to intervene in situations that involve sexual violence (Banyard, Plante, and Moynihan 2007, 464). The bystander role includes interrupting situations that could lead to assault before it happens or during an incident, speaking out against social norms that support sexual violence, and having skills to be an effective and supportive ally to survivors (Banyard, Plante, and Moynihan 2007, 467). In cases of sexual violence it is possible for those who witness abuse (bystanders) not to take action or to pretend that nothing happened for fear of being implicated in the case, and to take responsibility for witnessing the violence. It is therefore important for prevention programmes to focus on equipping those who witness sexual violence to be able to react to such cases in an appropriate manner as opposed to walking away and ignoring the situation.

Another programme that was evaluated included many aspects that contributed to its success, for example, teaching bystanders safe ways to intervene in situations of sexual and intimate partner violence and to prevent these forms of violence before they happen, or to serve as allies to victims after sexual or intimate partner violence has occurred (Moynihan et al. 2011, 706). Results from this bystander programme demonstrated sustained gains for attitudinal variables at a twelve-month follow-up; these included improved prosocial bystander beliefs which had a positive effect on both male and female students (Banyard, Moynihan, and Plante 2007).

In their study on a bystander approach, the evaluators found that using such a response to sexual and intimate partner violence prevention was effective at changing attitudes among incoming members (Moynihan et al. 2011, 706). The researchers were also encouraged by the high level of changes in efficacy, intent to help, and responsibility that occurred among the programme participants (Moynihan et al. 2011, 706). Therefore, when implemented as planned, a bystander sexual violence programme can yield positive results.

Other interventions have for various reasons focused on working only with male identifying students to counter patriarchy, gender norms, and violence. Foubert and Perry (2007, 72) evaluated a prevention programme similar to the one in Banyard, Moynihan and Plante's (2007) study which aimed to foster awareness of sexual violence, and the importance of intervening if one witnesses any kind of sexual violence. The programme trained male identifying students as potential helpers in cases of sexual assault. The author also found that some men who completed the programme demonstrated reduced rape myth acceptance (Foubert and Perry 2007, 73). This finding suggests that it is necessary to also engage with male identifying students in sexual violence prevention initiatives to ensure that they assist in fighting against acts of sexual violence on the university campus.

In another study, Vladutiu, Martin and Macy (2011, 68) examined research that evaluated the effectiveness of a college- or university-based sexual violence prevention programme in the United States of America. The findings from this study showed that college and university practitioners in higher educational institutions should understand the critical factors on campus that will inevitably influence the programme. These factors include considerations about the programme audience, the skills set of the facilitator (professionals and peer educators), the format and the content of the sexual assault prevention programme.

When presenting the results from evaluations that focus on bystander interventions, it is necessary to highlight components of successful interventions. Programme content is a key component of a successful college sexual violence prevention programme (Vladutiu, Martin, and Macy 2011, 77). The literature in this study found that teaching

topics about sexual assault were successful at improving outcomes related to rape attitudes, behavioural intentions, sexual assault knowledge, rape myth acceptance, rape tolerance, sexual victimisation, and the intent to engage in risky behaviours (Vladutiu, Martin, and Macy 2011, 77).

Effective sexual violence prevention interventions can also be presented in the form of workshops or classroom-based content and should be supplemented with campus-wide mass media events (Vladutiu, Martin, and Macy 2011, 77). When delivering the content, various mediums of teaching such as videos, films or presentations by rape survivors can be used. However, workshops and videos may be more cost-effective and less difficult to implement than classroom courses. Thus, the review implies that when rolling out a sexual prevention intervention, it is important to use a variety of training methods to enhance the training activities. This aspect contributes to a successful prevention programme. The literature presented focuses on preventing sexual violence through implementing face-to-face bystander approaches that encompass a number of programme components (Vladutiu, Martin, and Macy 2011, 77). These bystander approaches and programmes have been implemented in the United State of America.

Programme Description

In 2016 the HIV/AIDS, Inclusivity and Change Unit (HAICU) of the University of Cape Town implemented an online GBV and HIV prevention bystander intervention. The intervention, which was designed in workshop format, contained instructional videos with step-by-step processes on how to go through the various sections of the content areas. Participants could access the tool via an electronic link sent to them in an email. Transitioning from one section to the next was restricted to ensure that participants responded to all questions within a section before moving to the next part of the workshop. Since the content covered was sensitive and could trigger emotional reactions of some students, contact details of counselling and support services were provided to participants who experienced any form of trauma while completing the online workshop. The workshop was designed to last 60–90 minutes and contained a progress bar to show participants how far they had progressed.

Based on the programme structure it is clear that the online workshop model included short-, medium- and long-term outcomes based on clarifying gender norms, understanding the link between GBV and HIV, as well as understanding the role of the bystander in being able to deal with gender-based norms on campus. As bystanders, students could identify strategies to safely assess and then intervene in instances of imminent violence (Banyard, Moynihan, and Plante 2007, 464). The short-term outcomes relate to the knowledge acquisition factors (Anderson and Louw-Potgieter, 2012, 3). In this evaluation, these short-term factors are those that enable GBV and how to respond to acts of GBV. Medium-term outcomes are associated with changing

attitudes or perceptions and empowerment to respond in violent incidents (Anderson and Louw-Potgieter 2012, 3). Therefore, coupled with the online workshops as part of the GBV prevention response, HAICU conducted campaigns on campus highlighting the need to deal with GBV on campus, and how students can become active participants in reducing GBV, sexual assault, rape, rape culture and sexual violence on campus. The latter consists of the medium-term outcomes. The long-term outcomes include a decrease of incidence of GBV on campus (Anderson and Louw-Potgieter 2012, 3). It is understood that if the online tool is able to achieve its short-term, medium-term and long-term outcomes, it will ultimately be perceived as a successful tool in reducing incidences of GBV on campus.

Purpose of the Evaluation

We conducted a study on an online tool to further expand our reach to all students off-campus, especially those who were unable to attend our face-to-face peer education workshops. We also wanted to create an online platform for students to access the tool wherever they are and in their own time, thereby encouraging learning in an environment in which the students feel comfortable.

The main focus of this evaluation was to determine whether the online workshop changed the participants' knowledge and attitudes to deal with GBV on campus. The evaluation was also conducted to determine whether the online tool empowered participants to respond safely in violent situations and whether they knew which support structures to refer their peers to.

To respond to the above issues, a number of evaluation questions were formulated. These questions included: Did the participants understand the link between GBV and HIV? Did the participants increase their confidence to talk to their peers about the acts of GBV? Were the participants empowered to recognise and intervene in instances of GBV and were they able to identify the appropriate support structures on campus?

Definitions of Keywords

Bystanders are defined as those people who intervene in situations of sexual and intimate partner violence before they happen, or who serve as allies to victims after such violence has occurred (Moynihan et al. 2011, 706). For the purpose of this evaluation, a bystander is any person who witnesses a dangerous situation.

Evaluation is the use of social research methods to systematically investigate the effectiveness of social intervention programmes in ways that are adapted to their political and organisational environments (Rossi, Lipsey, and Freeman 2004, 16). For the purpose of this study, evaluation refers to investigating the effectiveness of an online workshop.

Gender-based violence (GBV) is defined by the United Nations as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or in private life" (WHO 1993, 4). For the purpose of this evaluation, GBV is defined as any act of violence towards both gender-conforming and gender-non-conforming individuals.

Online workshop is an intervention delivered and presented in virtual design (via computer) rather than being delivered face-to-face to small groups of students by a peer facilitator team (Kleinsasser et al. 2015, 234). In this study an online workshop is one that is delivered via a computer, in the absence of a facilitator.

Sexual violence is that action which encompasses many forms of violence from rape to sexual harassment and sexual trafficking (Jewkes, Sen, and Garcia-Moreno 2002; Kleinsasser et al. 2015). Sexual violence in this study is defined as any form of violence of a sexual nature.

Research Methodology

In order to assess the self-efficacy of the students in the online workshop, the bystander self-efficacy measure was used (Moynihan and Banyard 2008, 30). The questionnaire measured the level of confidence students had in their ability to effectively intervene as bystanders (Moynihan and Banyard 2008, 30). The HAICU developed a knowledge scale and skills scale. These scale questions were informed by the work of Banyard and Moynihan in 2005. The scale measured the students' knowledge of GBV and the role of a bystander.

The research was divided into two phases following a differences-in-differences (DID) research design. The first phase consisted of a baseline survey with the entire sample of students recruited from four separate mixed gender university residences. Participants from two of the residences were used as a control group, the other two as the intervention group. After the baseline survey the students of the intervention group were requested to complete an online workshop on perceptions of GBV. In phase two, the control group received the workshop and later completed another survey. (See Table 1.)

Table 1: Evaluation design and planned timeline

Groups		*Phase One*		*Phase Two*		
	May 2016		July 2016	August 2016		
First group	O_1	X	O_2			
Second group	O_1		O_2	X	O_3	

X = intervention workshop; $O_{1, 2, 3}$= assessment of outcome variables

The sample was drawn from a population of 5 500 residence students. The evaluation focused only on four mixed-gender residence students as they were the identified target group for the intervention. To obtain the participants' demographics, the evaluators requested the student housing database for the four mixed residences, and randomly selected participants using the Microsoft Excel random selection function. Participants were randomly selected from a stratified sample that was characterised by gender. Stratified random sampling was used to ensure that there was equal representation of male, female and gender-neutral identifying students. In the evaluation, two residences which are estimated to be roughly the same size in composition and that had a similar male-to-female ratio were randomly assigned to either intervention or control group. Evaluators randomly selected and invited 480 (240 male and 240 female) identifying students from the eligible residence population.

One challenge was an increasingly dropping response rate between the survey rates which saw the sample size of 194 in the first round going down to 114 in the second round, and 53 in the third round. It was therefore decided to treat the study as a two-stage rather than a three-stage design. The last survey completed by a participant was treated as the post-assessment (meaning that only the first and third survey round of participants who did all three rounds were used for analysis), and any participants who did not do any of the workshops were treated as the control group. Of the 194 students who participated in the evaluation, 79 completed only one round of the survey, meaning that these participants had to be excluded from the analysis. Of the remaining participants, 63 and 52 students completed two and three rounds of the survey respectively, making up the final sample (n = 115). Table 2 shows this participation.

Table 2: Participation in survey rounds

Workshop rounds	*No of participants*	*Brief explanation of sample*
1	79	Participated in only one round. Excluded from analysis
2	63	Included in analysis. Participated in rounds one and two
3	52	Included in analysis. Participated in rounds one, two and three
1 and 2 and 3	194	Total participation in evaluation
1 and 2	115	Final sample of evaluation

The intervention group consisted of 82 participants who participated in at least two survey rounds (baseline plus round 2/3) and one workshop. The control group consisted of 33 students who participated in at least two survey rounds but not the online workshop.

Ethical Considerations

Ethical approval to conduct the study was obtained from the Faculty of Health Sciences Ethics in Research Committee of the University of Cape Town. The Human Research Ethics Committee reference number issued for the study was HREC REF: 041/2015. Permission to access students for the research was granted by the University's Department of Student Affairs Executive Director.

Participants were provided with a written consent form informing them that taking part in the evaluation was voluntary and that they were free to withdraw from the evaluation at any time. Participants were assured that their responses would be treated with confidentiality. To protect the anonymity and to ensure confidentiality of the data, the respondents did not have to provide their names when completing the workshop so that the data gathered were not traceable to individual persons. As this was a sensitive topic, contact numbers for counselling and psychological services were made available in the online workshop and on the survey documents for students to access.

Data Analysis

The data were analysed using the Statistical Package for Social Sciences (SPSS) version 24. To answer the evaluation questions and to analyse the received data from the online workshop, descriptive statistics were used (Blanche, Durrheim, and Painter 2006).

Results

In this section, the evaluation results will be presented according to the evaluation questions.

Table 3: Gender of participants in the bystander intervention

Gender	*Number of participants*
Male	44
Female	69
Gender-neutral	2
Total	115

As illustrated in Table 3, the sample was biased towards female identifying respondents with 69 female (60%) versus 44 (38%) male identifying respondents. Two respondents (2%) did not classify themselves using binary gender descriptors (gender-neutral). It is important that the evaluation does not overlook minority groups, which

is why the evaluators included the two (2%) gender-neutral identifying respondents because they are as important as the participants who identify as masculine or feminine.

Were the participants confident to discuss acts of GBV with their peers?

First, the study participants were requested to express on a scale from 0 to 100 how confident they felt about talking to their peers about acts of GBV, based on 18 statements (about gender norms and perceptions) presented to them. These statements centred around three themes, namely expressing discomfort about language that perpetuates rape culture, calling for help in violent situations, and criticising language that offends women. The baseline results showed a high level of confidence for both the intervention and control group (75%). The post-treatment results were even higher (81% for the intervention group and 82% for the control group) but no statistically significant difference between the intervention and control group was detected.

A few noteworthy findings were made when looking at the individual variables making up the confidence scale. For example, only 34 per cent of the control group and 41 per cent of the treatment group said that they would "ask a stranger" if they needed to be walked home from a party. After the workshop, this increased to 53 per cent for both groups. But overall, the scale and the individual factors contributing to the scale reflected a generally strong confidence by the respondents, regardless of any intervention.

Did the participants understand the link between GBV and HIV transmission?

One open-ended question probed the respondents' understanding of the link between GBV and HIV transmission. Their responses were coded using the four categories, namely power inequality or imbalance in abusive relationships, inability to negotiate condom use, rape or forced sexual intercourse, and power inequality or imbalance in abusive relationships. The indicator used here takes the value "1" if the respondent mentioned any of these categories in the answer and "0" if not. If the response included at least one valid response category it was flagged as valid (1). During the first survey round, a higher proportion of members of both the control (70%) and treatment (76%) groups gave at least one valid answer compared to the end line (61% and 51%). The observed change, however, had arguably nothing to do with the intervention and more with the type of question (open-ended).

Did the participants know the support structures available on campus?

A series of open-ended questions asked whether the respondent would find help (contact the responsible person) in the event of experiencing GBV incidents, such as sexual harassment by students, sexual harassment by staff, and if a person who was raped requested your assistance. The knowledge scale was based on the number of

correct answers in terms of where to find help in the five mentioned types of instances of GBV. The results indicated that the number of correct answers barely changed between the baseline and the end line. On average all respondents provided 4.9 correct answers during the baseline compared to 5.3 (treatment group) and 5.1 (control group) during the end line.

The participants were asked to select which service they would refer to from the following list: Discrimination and Harassment Office (DISCHO); South African Police Services (SAPS); Residence Wardens (WARDEN); Campus Protection Service (CPS); Student Wellness Services (Wellness); Rape Crisis Centre (Rape Crisis); and a friend.

When asked to indicate which service they would refer to **in the case of rape,** DISCHO was mentioned by 34 per cent of the treatment students during the baseline but only by 27 per cent after having done the workshop. In contrast, only 2 per cent mentioned Rape Crisis pretreatment but 11 per cent mentioned it post-treatment.

The students were also asked to indicate which support structure they would go to **in case they experienced sexual harassment by fellow students**. DISCHO was mentioned by 40 per cent of the treatment participants during baseline but only 35 per cent after having done the workshop. The same percentage of students (34%) mentioned CPS both before and after the workshop.

Another question asked students to indicate **which support structure they would go to in case they experienced sexual harassment by staff**. DISCHO was mentioned by 39 per cent of the treatment participants during baseline and this increased to 41 per cent after having done the workshop. A total of 27 per cent mentioned CPS before and 25 per cent mentioned it after the workshop. In terms of **discrimination owing to sexual orientation**, 39 per cent of the treatment group indicated they would go to DISCHO. After the workshop, this percentage increased to 50 per cent.

The participants were also asked to **indicate which service they would report to in case a person who had been raped requested their assistance**. The results showed that DISCHO was mentioned by 35 per cent of the treatment students during the baseline but only by 26 per cent after having done the workshop. In contrast, only 27 per cent mentioned the SAPS pretreatment, but 30 per cent mentioned it post-treatment. Another observation made with respect to Wellness shows that pretreatment, 26 per cent would report to Wellness whereas after the workshop this result dropped to 21 per cent.

Were the participants empowered to intervene in incidents of GBV?

The respondents' perception of what constitutes GBV and their readiness to help in GBV situations was measured by their reaction to four different descriptions of incidents involving GBV using a scale from 1 (Victim does not need any help at all) to 7 (Victim needs help very much). The respondents were generally prepared to help (5.6) with no significant difference between treatment and control groups and pre- and post-period. From a gender perspective, it should be noted that in all instances female respondents were more likely to express an intention to intervene than male respondents. This result is supported by the study by Kleinsasser et al. (2015) about the Take Care online programme which showed that the intervention can increase feelings of efficacy for intervention in high risk situations of sexual violence.

Discussion

To the best of our knowledge, this is one of the first studies to be conducted in a South African university setting and can therefore make a valuable contribution to the existing body of knowledge. It is noted that the comparison of key outcomes of the intervention between control and treatment groups before and after the treatment shows that the intervention did not have a statistically significant effect on the participants. Nonetheless, some valuable observations can be made from the evaluation. The students generally showed high levels of knowledge of GBV issues, positive perceptions of gender norms and the capacity to intervene in instances of GBV. This alone would make it difficult for any intervention to increase these levels even further at a significant rate. The results also showed that students had high levels of confidence with regard to implementing respective behaviours in response to GBV for both the intervention and control groups. This may be owing to the fact that at the time the study was conducted, the students were aware of the university initiatives related to sexual violence prevention that were taking place on the campus.

A few months before implementing the evaluation, there had been a number of female student attacks, assaults and rapes by an alleged "Rhodes Memorial serial rapist" who was later caught and arrested by police. Secondly, and subsequently, the university instituted a Sexual Assault Response Team (SART) in response to an increase in the number of sexual violence cases that occurred on and off campus. SART is a collaborative collective designed to empower the university community with the knowledge and skills to effectively respond to and prevent sexual violence on campus. Since the team's inception, staff and students were kept informed, through email communication and quarterly reports, of the work of the SART and of all known reported cases of sexual violence that occurred on campus.

At the time of the release of the SART's second quarterly report for 2016, 19 incidents of sexual harassment were formally reported to the university since the beginning of

2016. Seven rape cases were also reported during this period, with two that occurred in university student residences, four incidents that took place off campus and one case where the survivor did not identify whether the incident took place on or off campus. Lastly, a number of anti-sexual violence student campaigns and protests, led by a student activist collective, were held on the university campus before and during the time this research was being conducted. The group called on the university to be open about the perpetrators that were part of the campus community. These events may have influenced the student's knowledge, attitudes and behaviours with regard to responding to GBV and sexual violence.

The results indicated that gender plays a crucial role in different perceptions of GBV and situations involving GBV, with female respondents generally exhibiting more positive attitudes than male respondents. This points to the possible need for more gender-specific interventions, for both male and female identifying students. These interventions need to be delivered in face-to-face workshops by peer educators who are trained to deliver content specific to GBV and bystander interventions. Campbell (2004, 198) emphasises that face-to-face education enables gender norms to be challenged through the process that underlies successful peer education.

More recently, research indicates that there is a high willingness by youth populations to access internet-based information for health information and therefore supports the notion that peer education on matters related to public health and prevention education could potentially be conducted online (Pettifor et al. 2013; Trapence et al. 2012; Young, Szekeres, and Coates 2013, 2). The accessible nature of this online workshop makes it a youth-friendly tool in providing information about health and support services that seek to attract and retain students. However, more rigorous research will need to be conducted to link prevention behaviour to the use of online education tools.

The students through the online intervention were able to understand their role if a situation happened and to have a response to a GBV type of situation. The results also indicated that the students were able to direct other students or themselves to the appropriate services on campus that can assist a student in need. Further to these benefits, the evaluation conducted contributes to our understanding of GBV in a tertiary sector as well as if such an intervention could be used with other young people in society. These findings are the major strengths of the evaluation.

The study has certain limitations. It was initiated by the HAICU to four mixed-gender university residences and therefore included only these students living on campus. The generalisability of the current results to the entire university student population should therefore be treated with caution. The low response rate and retention rate of the students who participated in the study may have impacted on the results and also limits the extent to which the findings can be generalised to all students at the

university. In addition, the timing between the different phases and steps (for example pretest, intervention and post-test) of the research process for both intervention and control groups was too short. This may have affected the significance of the results.

In relation to healthcare professionals and policymakers, the online workshop is accessible and can be used at a convenient time. Online mechanisms imply that participants do not have to go to a venue to attend a face-to-face prevention education workshop (Young, Szekeres, and Coates 2013, 2). There is value for healthcare professionals in utilising this tool to access GBV prevention content, at their own time. However, further rigorous testing will need to be conducted to directly link the change in behaviour to the online learning mechanism. Factors that need to be considered when designing or administering online workshops include anonymity, time limitation and internet accessibility (Rhodes et al. 2010, 2011; Hightow-Weidman et al. 2011; Young, Szekeres, and Coates 2013).

Conclusion

The findings of this research revealed that the online workshop did not influence students' confidence to talk about GBV acts with their peers and also did not influence their understanding of the link between gender-based violent behaviour and HIV. This is probably owing to the fact that at the time the evaluation was conducted, students were aware of and informed about a number of issues and university initiatives related to sexual violence that were taking place on campus. In addition, the timing between the different phases and steps (for example pretest, intervention, and post-test) of the research process for both intervention and control groups was too short, which might have affected the significance of the results. The evaluation recommends that more time be granted to participants between follow-up periods in the future to examine whether there would be significant changes in results. The findings from this evaluation generate opportunities to further explore additional advances in online bystander models within an institutional setting.

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References

Anderson, T. N., and J. Louw-Potgieter. 2012. “An Implementation Evaluation of a Voluntary Counselling and Testing Programme for the Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS).” *SA Journal of Industrial Psychology* 38 (1): 1–10.

Banyard, V. L., M. M. Moynihan, and E. G. Plante. 2007. “Sexual Violence Prevention through Bystander Education: An Experimental Evaluation.” *Journal of Community Psychology* 35 (4): 463–81. https://doi.org/10.1002/jcop.20159.

Blanche, M. T., K. Durrheim, and D. Painter. 2006. *Research in Practice: Applied Methods for Social Sciences*. 2nd ed. Cape Town: University of Cape Town Press.

Campbell, C. 2004. “Creating Environments that Support Peer Education: Experiences from HIV/AIDS-Prevention in South Africa.” *Health Education* 104 (4): 197–200.

Duma, S., T. De Villiers, D. Newman-Valentine, S. Kyobula-Mukoza, S. Gimba, N. Abrahams, P. Meyers, and K. Thomas. 2014. “Violence against Women in the University Residence: A Student Leadership Participation.” Research Report, University of Cape Town.

Foubert, J. D., and B. C. Perry. 2007. “Creating Lasting Attitude and Behavior Change in Fraternity Members and Male Student Athletes: The Qualitative Impact of an Empathy-Based Rape Prevention Program.” *Violence against Women* 13 (1): 70–86. https://doi.org/10.1177/1077801206295125.

Giovanelli, T. S., and L. Jackson. 2012. “Sexual Violence Perceptions among Christian College Students.” *Mental Health, Religion and Culture* 16 (3): 254–72. https://doi.org/10.1080/13674676.2012.657618.

Hightow-Weidman, L. B. , B. Fowler, J. Kibe, R. McCoy, E. Pike, M. Calabria, and A. Adimora. 2011. “HealthMpowerment.org: Development of a Theory-Based HIV/STI Website for Young Black MSM.” *AIDS Education and Prevention* 23 (1): 1–12. https://doi.org/10.1521/aeap.2011.23.1.1.

Jewkes, R., P. Sen, and C. Garcia-Moreno. 2002. “Sexual Violence.” In *World Health Report on Violence and Health*. Geneva: World Health Organization.

Kleinsasser, A., E. N. Jouriles, R. McDonald, and D. Rosenfield. 2015. “An Online Bystander Intervention Program for the Prevention of Sexual Violence.” *Psychology of Violence* 5 (3): 227–235. https://doi.org/10.1037/a0037393.

Moynihan, M. M., and V. L. Banyard. 2008. “Community Responsibility for Preventing Sexual Violence: A Pilot Study with Campus Greeks and Intercollegiate Athletes.” *Journal of Prevention and Intervention in the Community* 36 (1–2): 23–38. https://doi.org/10.1080/10852350802022274.

Moynihan, M. M., V. L. Banyard, J. S. Arnold, R. P. Eckstein, and G. Jane. 2011. “Sisterhood may be Powerful for Reducing Sexual and Intimate Partner Violence: An Evaluation of the Bringing in the Bystander In-Person Program with Sorority Members.” *Violence against Women* 17 (6): 703–19. https://doi.org/10.1177/1077801211409726.

Pettifor, A., L. G. Bekker, S. Hosek, R. DiClemente, M. Rosenberg, S. S. Bull, S. Allison, S. Delany-Moretlwe, B. G. Kapogiannis, and F. Cowan. 2013. “Preventing HIV among Young People: Research Priorities for the Future.” *Journal of Acquired Immune Deficiency Syndrome* 63 (Suppl 2): S155–60. https://doi.org/10.1097/QAI.0b013e31829871fb.

Rhodes, S. D., K. C. Hergenrather, J. Duncan, A. T. Vissman, C. Miller, A. M. Wilkin, J. Stowers, and E. Eng. 2010. “A Pilot Intervention Utilizing Internet Chat Rooms to Prevent HIV Risk Behaviors among Men who have Sex with Men.” *Public Health Reports* 125 (Suppl 1): 29–37. https://doi.org/10.1177/00333549101250S105.

Rhodes, S. D., A. T. Vissman, J. Stowers, C. Miller, T. P. McCoy, K. C. Hergenrather, A. M. Wilkin, M. Reece, L. H. Bachmann, A. Ore, M. W. Ross, E. Hendrix, and E. Eng. 2011. “A CBPR Partnership Increases HIV Testing among Men who have Sex with Men (MSM): Outcome Findings from a Pilot Test of the CyBER/Testing Internet Intervention.” *Health Education and Behaviour* 38 (3): 311–320. https://doi.org/10.1177/1090198110379572.

Rossi, P. H., M. W. Lipsey, and H. E. Freeman. 2004. *Evaluation: A Systematic Approach*. Thousand Oaks: Sage.

Trapence, G., C. Collins, S. Avrett, R. Carr, H. Sanchez, G. Ayala, D. Diouf, C. Beyrer, and S. D. Baral. “From Personal Survival to Public Health: Community Leadership by Men who have Sex with Men in the Response to HIV.” *Lancet* 380 (9839): 400–10. https://doi.org/10.1016/S0140-6736(12)60834-4.

Vladutiu, C. J., S. L. Martin, and R. J. Macy. 2011. “College- or University-Based Sexual Assault Prevention Programs: A Review of Program Outcomes, Characteristics, and Recommendations.” *Trauma, Violence and Abuse* 12 (2): 67–86. https://doi.org/10.1177/1524838010390708.

WHO (World Health Organization). 1993. *Global and Regional Estimates of Violence against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-Partner Sexual Violence*. Geneva: World Health Organization.

Young, S. D., G. Szekeres, and T. Coates. 2013. “The Relationship between Online Social Networking and Sexual Risk Behaviors among Men who have Sex with Men (MSM).” *PLoS ONE* 8 (5). https://doi.org/10.1371/journal.pone.0062271.