Getting it right from the start: Violence prevention for women and children in the first 1,000 days

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> *"Breaking this vicious cycle [of violence] – for the child, the adult and for society – requires that every child lives free from all forms of violence from the very start."*
>
> *Office of the Special Representative of the Secretary-General on Violence against Children*[1]

Everyone has the right to live free from fear, harm, and violence. Yet, exposure to violence often begins early – in pregnancy and the first few years of life. It is therefore vital to intervene early to address risk factors for violence when they first emerge, to improve children's health, education and social outcomes. Preventing violence in early childhood can also help interrupt the cycle of violence across the life course and across generations.

The early years provide a unique opportunity to strengthen protective factors – such as secure caregiver-child attachment, maternal mental health and social support networks – to promote the safety, resilience and well-being of both women and children.

There is increasing evidence that violence against women and children in the home share common risk factors, are closely connected and can reinforce each other.[2] It is therefore crucial to adopt an intersectional approach and to develop effective prevention strategies that address the family or household as a whole, and not just women or children in isolation.

Effective violence prevention also requires collaborative efforts that bring together a range of sectors – health, social services, education, justice and community-based systems – to address the underlying drivers of violence. Within this multisectoral approach, the health sector plays a pivotal role through the provision of a range of maternal and child healthcare services. These routine contacts with pregnant women, caregivers, infants and families offer entry points for preventing violence and promoting safe and supportive family environments.

This chapter explores the opportunities for integrating violence prevention strategies into health services for women and children in the first 1,000 days of life. It focuses on the first 1,000 days – from conception until the child's second birthday. This is for two reasons: first, to emphasise the importance of early intervention during this rapid period of development, when the benefits of intervention are amplified;[3] and second, to align with the 2015 National Integrated Early Childhood Development Policy (NIECD Policy), which mandates the health sector with the responsibility for providing services to vulnerable children under two years and their families[4]. While the focus here is on the first 1,000 days, it is important to sustain multisectoral violence prevention efforts across the life course.

The chapter highlights how both women and children are particularly vulnerable to violence during this period. It provides a brief overview of strategies that are recognised to be effective in preventing violence against women and children; and then explores how these can be integrated and strengthened within health services.

The chapter focuses on child maltreatment and intimate partner violence (IPV). IPV is the most common form of violence experienced by women,[5] although other forms of gender-based violence during the first 1,000 days, including obstetric violence,[6] may intersect with IPV and increase women's vulnerability.

Why is it important to prevent violence in the early years?

Pregnancy and the first few years of a child's life hold enormous promise for shaping lifelong health and well-being, offering a unique opportunity to support safe, nurturing environments. Yet it is also a time of heightened vulnerability for both women and children, with stresses that can increase the risk of violence and long-term harm.

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Table 2: Examples of risk and protective factors for violence in the first 1,000 days

Risk factors	Protective factors
• Age and developmental capacity • Disability • Pregnancy • Witnessing or experiencing violence in childhood • Attitudes and social norms that condone violence, including physical punishment • Harmful gender norms, including around who is responsible for caring for infants • Low socio-economic status, financial and food insecurity • Poor caregiver mental health • Unprocessed trauma and anger • Misuse of alcohol and/or drugs • Limited social support • Limited access to services	• Strong attachment and bonding • Responsive caregiving • Understanding of infants' needs and development • Greater gender equality in intimate relationships • Shared caregiving for infants, toddlers • Support system to assist families with responsive care • Empowerment and support for women, including income support and economic empowerment • Support and accountability for men • Support services (screening during antenatal care, well-baby services, parent support groups etc.) • Safe environments for infants, women

Pregnancy and the first years of childhood lay the foundation for healthy growth, learning and development. Secure and nurturing relationships between an infant and his or her caregivers build a sense of security and resilience.[7] In contrast, exposure to violence in the home in early childhood – whether experienced directly or witnessed – can have profoundly negative and lasting consequences.

The brain undergoes rapid growth and organisation in early childhood, and exposure to violence can disrupt the architecture of neural circuits in the brain, with long-term consequences for the child's ability to manage emotions, think, and connect with others[8] (see Box 5). It also increases the risk of children experiencing and/or perpetrating violence later in life, feeding into intergenerational cycles of violence.[5, 9, 10] While these impacts are not specific to the first 1,000 days, infants are especially vulnerable to child maltreatment in the home because of their dependence on caregivers and limited interaction with others outside the home.

This is also a period of increased stress and vulnerability for women, with a heightened risk of IPV.[11, 12] A 2015 longitudinal study in Durban found that more than 20% of the women in their sample experienced at least one act of physical, psychological

Box 5: Violence, toxic stress and the developing brain

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The first 1,000 days of life are a sensitive window when the brain grows and develops at the greatest rate of any time during the whole human lifespan. During this period, exposure to violence or neglect may cause emotional harm, but also may alter biology in ways that can become embedded and difficult to change.[43]

Violence towards a mother in pregnancy activates her stress response, raising cortisol levels that cross the placenta and shape foetal brain development.[44] After birth, witnessing or experiencing violence triggers the infant's own fight, flight or freeze response. While short bursts of stress hormones protect in moments of danger, repeated exposure can keep the body chronically on high alert.

In early life, such chronic stress reshapes the brain's set-points, altering the growth patterns and connections of important areas of the brain that are responsible for managing fear, memory and impulse control. These changes can leave a child less able to learn or regulate emotions, predisposing them to poorer cognitive and health outcomes across the life course.[45]

The consequences can be both immediate and long-term. Children exposed to violence show higher rates of emotional difficulties, school struggles, asthma, infections and later chronic disease.[46] In the longer term, trauma in the early years may fuel a cycle of violence: those who experienced multiple forms of childhood violence are more likely to be involved in violent relationships as adults, either as victims or perpetrators.[47] Early intervention offers the chance to break intergenerational cycles and support healthy brain development.

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or sexual IPV during pregnancy, and nearly a quarter of the women had at least one such experience during the first nine months following childbirth.[13]

Pregnancy can trigger or worsen violence in relationships, including among teens, often due to changes in power dynamics, financial stress or a partner's perceived loss of control.[14] This violence harms both mother and child, causing physical and mental health challenges for women such as depression, anxiety, post-traumatic stress disorder and chronic pain.[15] Violence during pregnancy also increases the risk of miscarriage, premature labour and low birth weight.[13] These impacts can impair a woman's capacity to care for her child, disrupting bonding and attachment and increasing the risk of child maltreatment.[10]

What are the risk factors for violence in the home during the early years?

Historically, violence against women and violence against children have been treated as distinct and separate issues, with limited attention paid to how they intersect or influence one another. But recent research highlights that these forms of violence often co-occur within the same households and share the same risk factors.[2]

Examples of shared risk factors for women and children include gender inequality and discrimination, male dominance in the household, marital conflict, harmful use of alcohol and drugs, a lack of responsive institutions and weak legal sanctions against violence.[2]

Some risk factors for violence may be more pronounced at certain stages of life. In the early years, attachment and bonding are crucial for building secure relationships that promote resilience and reduce the likelihood of child maltreatment.[7] Poor caregiver mental health can be both a cause and consequence of violence, while strong social support and attention to caregiver mental health can serve as protective factors for both women and children. More gender-equitable caregiving for babies and young children can also help to reduce risk.[16] The misuse of alcohol and drugs is another risk factor that can

Table 3: Nurturing Care Framework

NCF domain	Links to violence prevention	Interventions
Good health	• Physical and mental ill health in the home can increase stress, increasing the risk of violence. Alcohol and substance use are risk factors for violence, while mental health concerns are both a risk factor for and consequence of violence.	• Health services (antenatal and postnatal care) are key entry points for identifying and responding to violence. • Health workers can be trained to screen for substance abuse, mental health and violence, provide immediate care and refer for further support.
Adequate nutrition	• Food insecurity and financial stress are risk factors for both IPV and child maltreatment.	• Income support (of sufficient value) can improve food security and reduce financial stress and dependency. • In Tanzania, a programme that combined nutrition and parenting interventions that actively involved fathers was found to reduce mothers' exposure to IPV.[20]
Responsive caregiving	• Responsive caregiving helps prevent violence by strengthening emotional bonds, supporting emotional regulation, reducing caregiver stress and modelling non-violent behaviour to create safe and secure environments for both children and adults.	• Gender-transformative parent and family support programmes that promote responsive caregiving as well as care for the well-being of caregivers; actively engage men as well as women; and challenge harmful gender and social norms have been shown to reduce both IPV and child maltreatment. • Such interventions can include peer support groups, home visits and curriculum-based programmes.
Safety and security	• Providing safe, stable and nurturing environments free from physical and emotional harm is core to violence prevention.	• Interventions include ensuring access to safe housing and communities for women and children.
Early learning	• Stimulating environments provide protection by promoting healthy child development and reducing the risk of neglect, abuse or isolation. Engaging with caregivers can offer needed social and emotional support.	• Childcare or early learning programmes that promote non-violence through engagement with caregivers can contribute to violence prevention both within these settings and at home.

exacerbate violence in the home[2, 17] and can contribute to foetal alcohol syndrome in infants.

Understanding risk and protective factors outlined in Table 2 can help identify opportunities for prevention. This includes efforts to address the underlying risks or drivers of violence and strengthen protective factors.

Why integrate violence prevention strategies for women and children in the first 1,000 days?

Given the lasting impact of early adversity, there have been calls for integrating violence prevention and early childhood development (ECD) services.[18, 19]

Nurturing care for infants starts in the home, with parents and caregivers playing a central role in creating safe and loving environments (see Table 3). This is emphasised in the 2018 Nurturing Care for Early Childhood Development Framework,[7] which also highlights the important role of health systems in promoting and supporting nurturing care for young children.

In South Africa, the package of services to support the holistic development of infants and young children is defined by the NIECD Policy. The policy recognises the health sector's ability to reach pregnant women, new parents and caregivers, and young children, and it designates the Department of Health – in close collaboration with the Departments of Social Development and Basic Education – as responsible for services to children under two years. The policy expands the health sector's role beyond its traditional focus on delivering health and nutrition programmes for pregnant women, new parents and children to include parenting support and the promotion of learning and play opportunities for children from birth to two years, offered through health facilities and home visits by community health workers for those at risk of poor developmental outcomes.[3, 4]

The NIECD Policy acknowledges the importance of preventing violence in early childhood but does not identify violence prevention as a priority. Other recent policies with an explicit focus on violence prevention – such as the National Child Care and Protection Policy (2019), the National Strategic Plan for Gender-based Violence and Femicide (NSP-GBVF, 2020), and the Integrated Crime and Violence Prevention Strategy (2022) – have a stronger focus on the need to start prevention efforts in early childhood, recognising that early exposure to violence affects outcomes later in life.

For example, the prevention pillar of the 2020 NSP-GBVF includes integrating non-violent and gender transformative approaches into evidence-based parent support and ECD programmes.[21] The NSP-GBVF tasks the Department of Health with providing services to survivors – such as immediate care, mental health support and the collection of forensic evidence – but also identifies a role in prevention. This includes training health workers in gender-based violence prevention; incorporating violence prevention into substance abuse, sexual and reproductive health (SRH), and HIV prevention interventions; and equipping lay mental health workers to provide community level support.[21]

South Africa's policy framework recognises the importance of starting violence prevention early in the life course, and the role of the Department of Health in advancing this through antenatal, postnatal and child health visits in the first 1,000 days. But there has been less focus on how to use these services as an entry point to support both women and children by identifying interconnected risks, providing care and facilitating referrals to additional support services.

What do we know about what works to prevent violence?

Two global frameworks – INSPIRE[22] and RESPECT[23] – identify evidence-based strategies for preventing violence against children and violence against women, respectively. Both are built on public health approaches to preventing violence and apply evidence-based, population-level strategies to address risk and protective factors across the life course highlighting the importance of multisectoral collaboration.

Selected strategies from these frameworks that are relevant to the early years include:

- **Challenging harmful social and gender norms.** This includes addressing beliefs that caregiving is solely a woman's responsibility, that men should not be involved in early childcare, that children need to be punished physically to learn, or that women should tolerate abuse to keep the family together. Interventions that promote shared caregiving, positive discipline and equal decision-making within households help shift these norms and reduce violence against both women and children.[24] Gender-transformative programmes that engage fathers of young children and their partners – such as Bandebereho[25] in Rwanda (see Case 1) and REAL Fathers[16] in Uganda – have shown positive results in shifting attitudes and behaviours and reducing IPV against women and violence against children.
- **Parent and caregiver support** is especially important for vulnerable families in the early years. This support can be provided through antenatal support groups, parenting or family support programmes, couples programmes, or initiatives targeting new fathers – all aimed at supporting caregivers and fostering healthy relationships. A key lesson emerging from programme evaluations is that engaging both women and men is more effective in reducing IPV than

Case 1: Bandebereho – Working with men and their partners

The Bandebereho programme in Rwanda is a gender-transformative programme that works with fathers of young children to prevent violence in the home.[25] The programme was adapted to the Rwandan context from Program P and implemented by the Rwanda Men's Resource Centre and Equimundo. It engages men and their partners to promote reproductive, maternal and child health, men's caregiving and violence prevention. It uses fatherhood as an entry point to promote gender equality and encourage positive changes in men's relationships with their partners and children, shifting underlying power dynamics.

During the first randomised control trial, fathers of young children and soon-to-be fathers attended 15 small group sessions led by trained peer facilitators (fathers). The sessions consisted of critical reflection, discussion and skills-building, and their partners attended eight of the sessions. Local health providers and police participated in selected sessions, and the programme also trained health providers and sponsored community-level activities or campaigns.[41] These sessions aimed to transform harmful gender attitudes and promote more equitable, caring and non-violent relationships.

The randomised controlled trial evaluation found that Bandebereho substantially reduced rates of intimate partner violence and harsh punishment against children, even six years after the intervention.[25] The emphasis on working with men and women to challenge inequitable norms, build skills and improve the quality of both couple and parent–child relationships is seen as critical to the lasting reductions in violence.[25] The focus on the transition to fatherhood – a time when men and their partners are more likely to be open to change – is also likely to have contributed to the lasting effects.[25]

Bandebereho is currently being scaled up and institutionalised in the health system, in partnership with the Rwandan government, through the training of community health workers to deliver the programme as part of their routine work.[42]

working with women or men in isolation,[26] and that parent support programmes that overlook IPV may be less effective in reducing violence in the home.[27]

- Other key strategies include creating **safer physical environments** (see Case 14 on p.93), addressing structural drivers of violence such as poverty through **income support and women's economic empowerment,** and ensuring access to **effective response and support services** to prevent the recurrence of violence and mitigate its impact.

While these strategies may not initially appear to be health system interventions, they are integral to a public health approach that prioritises preventing violence rather than only responding to its effects.

What are the opportunities for strengthening violence prevention in the first 1,000 days?

The health sector has frequent contact with pregnant women and young children and therefore has the potential to serve as a gateway to help women and children access services and support from other sectors. There are clear entry points for integrating violence prevention into health sector services during the first 1,000 days, either through the direct actions of health workers or by using health facilities as platforms for delivery.

Some interventions can be embedded within the health system, while others involve referrals to other services as part of a multisectoral approach.

- Antenatal and postnatal clinic visits for well-baby care and immunisation offer opportunities to **strengthen screening** for substance abuse, mental health problems and exposure to violence. South Africa's National Integrated Maternal and Perinatal Care Guidelines[28] support screening in all three areas. Rather than universal screening for IPV or child maltreatment, the World Health Organization advises that health workers assess for violence when risk factors or indicators of abuse are present.[29, 30] Risk assessments and safety planning in cases of IPV should also consider the needs and safety of children in the home, including those who witness domestic violence, and it is essential to ensure privacy and safety to support safe disclosure[29].
- **Training and capacity building** for health workers is crucial to ensure they can: screen for violence safely and sensitively, in line with clinical guidelines;[29] provide first-line support; and make appropriate referrals. This includes training on survivor-centred approaches, legal reporting requirements, managing the potential tensions between child protection and women's rights to privacy and autonomy, and navigating referral pathways to support services for women and children (see Case 2: Philisa)

- Since the inclusion of a chapter on **mental health** in the National Maternal and Perinatal Care Guidelines in 2024, there have been calls to strengthen training programmes to equip health workers with the skills needed to provide primary level mental healthcare.[31] This should be supported by clinical supervision, mentoring and investment in well-functioning referral pathways.[31]
- The revised **Road to Health Book** offers another opportunity to strengthen appropriate screening. Protection of children is a key pillar of the Road to Health Book, but it is currently focused on protection against preventable diseases and injuries.[32] The book also includes a section on children who need extra care in order to identify potential social risk factors,[33] but this does not specifically include violence in the home. A more explicit focus on violence could be incorporated but would need to be accompanied by training of health workers on the clinical guidelines, first-line support and referral pathways.
- Antenatal and postnatal care and well-baby visits also provide an opportunity to implement **gender-transformative strategies** that actively involve men by encouraging them to attend clinic visits and support their partners during childbirth or referring them to structured interventions that support men's own parenting journey (see Case 1 and Case 3).
- **Adolescent- and youth-friendly services** offered at clinics play a role in violence prevention by providing access to SRH services, which can empower young people to make informed decisions and reduce their vulnerability to sexual and gender-based violence. These services are particularly important for adolescent girls and teen mothers, who often face heightened risks of violence, stigma and exclusion. The NSP-GBVF calls for integrating and strengthening GBVF prevention components in SRH services.[21]
- **Public communication and community messaging initiatives** such as MomConnect and the Side-by-Side campaign offer opportunities to expand violence prevention messaging, promote engagement of fathers and challenge harmful gender and social norms. Messages can focus on violence prevention strategies, such as managing stress and anger, building healthy relationships, encouraging shared

Case 2: Philisa: Child protection services at Red Cross War Memorial Children's Hospital

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"Philisa" is a Xhosa word meaning "to be healthy, to heal, or to make someone feel well." This word forms the foundation of Philisa's mission: to bring healing and wholeness to every child, parent and family member affected by abuse and violence.

Established in 2023, the Philisa unit at Red Cross War Memorial Children's Hospital aims to provide holistic, trauma-informed care for children who have experienced any form of abuse. The objective is to empower and equip healthcare professionals to identify vulnerable children and families early on – allowing the healing process to begin from the very first encounter. Through targeted training and ongoing support, doctors' and nurses' confidence and competence in managing these complex and sensitive situations have significantly improved. A dedicated interdisciplinary healthcare team ensures each child receives the highest standard of care, always within the context of their unique social environment.

South Africa is among the most violent countries in the world. Since inception, Philisa has seen a troubling increase in all types of child maltreatment. One particularly concerning trend is the strong link between intimate partner violence and pediatric injuries. The youngest patient affected by such violence was a three-week-old baby caught in a domestic dispute. He sustained multiple injuries, including a traumatic brain injury and a femur fracture, after a cupboard was pushed and fell on both him and his mother. Further x-rays revealed fractures consistent with abuse occurring soon after birth. A coordinated, multidisciplinary approach – including both medical and surgical care – was crucial in managing his injuries.

Thanks to the dedication of the social work team and psychologist, Philisa was able to develop a safe, comprehensive discharge plan that prioritised the well-being of both mother and child. This included medical and neurodevelopmental follow-up, psychosocial support and integration with community-based resources to ensure continuity of care and long-term safety.

Despite the emotional toll of these cases, staff remain deeply grateful to play a role in protecting children and supporting their healing. It is hoped that through Philisa, each child touched by trauma is given a chance to feel safe, seen, and begin to heal.

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Case 3: Male partners' experiences of early pregnancy ultrasound scans in Soweto, South Africa

It is unusual for men in South Africa to attend antenatal visits. This is despite evidence that suggests that including fathers or male partners in perinatal programmes positively helps strengthen children's attachment,[i] emotional regulation[ii] and cognitive development.[39] Such interventions can also positively impact men's well-being and their relationship with the mother and child.[39]

The Healthy Pregnancy Healthy Baby Study in Soweto, South Africa, aimed to explore the experiences of male partners who attended early pregnancy ultrasound examinations.[40] Pregnant women attending ultrasound examinations were invited to bring their partners with them, and both completed questionnaires that included questions on antenatal attachment (the emotional bond that develops between a caregiver and the unborn child before birth). Based on a sample of 102 mother-partner pairs, the study found that participating in the ultrasound examination had a positive effect on men and their thoughts regarding their developing baby, with 30% stating that they were ready or excited to be a father. Twenty-eight percent believed their relationship with the mother was stronger as a result of participating in antenatal care.

Based on these findings, the researchers argue that health services in South Africa should accommodate partners/fathers and encourage them to attend antenatal care, including pregnancy ultrasound scans. Simple gender-transformative interventions such as this are needed to encourage more men to be involved from conception, potentially addressing individual, familial, societal and structural barriers to involvement of fathers in longer-term maternal and child care.

i Attachment can be understood as the emotional bond between an infant and his or her caregiver(s).
ii Emotional regulation is the ability to understand and manage our feelings.

childcare and decision-making, and promoting alternatives to physical punishment.

- The NIECD Policy envisions community health workers (CHWs) conducting **home visits** to vulnerable mothers[iii] and caregivers of young children to support maternal and infant health and optimal child development. These visits offer an opportunity to introduce gender-transformative strategies, provide first-line mental health support, promote responsive care of young children, and strengthen safe, nurturing relationships in the household beyond the mother and child. They also provide an entry point for referrals to evidence-based parent or family support services that consider both the couple's relationship and their relationship with their child(ren), and incorporate other mechanisms that have been found to reduce both IPV and child maltreatment, such as improving communication and conflict resolution skills, challenging harmful social norms, and increasing awareness of the impacts of IPV and child maltreatment on children.[27] Clinic- and community-based support groups for women or parents and-babies offer similar opportunities.
- The NIECD Policy also recommends **pre-delivery registration** for the Child Support Grant (CSG) to ensure that infants benefit from birth. While the CSG has demonstrated multiple benefits for children,[34] uptake remains lower among caregivers of younger children, especially those under one year.[35] Expanding antenatal care services to include CSG registration could also serve as an entry point for connecting women with other forms of **income support** including the Social Relief of Distress grant and proposed Maternal Support Grant[36] as well as child maintenance and economic empowerment programmes. Such support has the potential not only to improve maternal and infant health but also to reduce women's financial dependence on abusive partners, thereby enhancing their ability to leave violent relationships.

What are the systemic challenges?

Maternal and child healthcare services therefore offer critical opportunities for violence prevention, but implementation is constrained by several systemic challenges.

- Key services outlined in the NIECD Policy such as home visits by CHWs are not fully operational,[37] hindered by funding constraints and concerns about overburdened CHWs. Parent-support programmes – mostly outside the health sector – tend to be small-scale, are not sufficiently gender-transformative, and many rely on structured curricula that do not account for the diverse needs and family forms in South Africa[37].
- Referral systems are often unclear, underfunded and fragmented, with separate pathways for women and children hindering integrated care and support. There is

iii The NIECD defines vulnerable mothers as including include teenage mothers; mothers with problems with mental health, substance use and/or survivors of domestic violence; and mothers of children with developmental difficulties and/or disabilities.

an urgent need to invest in response services, including psychosocial support and shelters that serve both women and children. Such intersectional approaches are essential, but they must carefully balance children's right to protection and women's right to autonomy (see page 129).

- Despite policy commitments in the NIECD Policy and NSP-GBVF that support multisectoral collaboration, siloed operations, weak coordination mechanisms and limited accountability have undermined implementation.[37, 38] Realising the potential for intersectional violence prevention in the first 1,000 days will require careful consideration of frontline capacity, training gaps and resourcing. Without sustained investment and explicit policy support, these efforts risk being treated as peripheral to core service mandates.

Conclusion

Preventing violence against women and children must begin early in life and be sustained throughout the life course. This chapter argues that the health sector has a vital role to play – particularly during the first 1,000 days of life – by integrating family-centred, gender-transformative strategies into routine maternal and child health services.

Integrating violence prevention for both women and children into routine health services during the early years offers an accessible and cost-effective way to reach vulnerable women and children at scale. However, systemic barriers such as limited resources, weak coordination, and the need to navigate siloed referral pathways hinder effective delivery. To be effective, violence prevention must be recognised as essential to young children's development and prioritised in the revised NIECD Policy, with support from broader policy tools such as the Medium Term Strategic Framework.

Identifying entry points to address violence against women and children within maternal and child health services can strengthen violence prevention and response efforts in South Africa. While integration may not always be feasible, improved collaboration and greater awareness of the intersections between these forms of violence can improve intervention effectiveness. Investing early in violence prevention lays the groundwork for the lifelong health and well-being of women and children, upholding their rights to life, dignity, and safety.

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