Peace begins @ Home

The Gender Based Violence Indicators Study

Limpopo Province of South Africa



Gender Links (GL) is a Southern African NGO that is committed to a region in which women and men are able to participate equally in all aspects of public and private life in accordance with the provisions of the Southern African Development Community (SADC) Protocol on Gender and Development. GL achieves its vision by coordinating the work of the Southern African Gender Protocol Alliance formed around the sub-regional instrument that brings together all key African and global commitments for achieving gender equality. Working with partners at local, national, regional and international level, GL aims to:

- Promote gender equality in, through the media, and in all areas of governance.
- Develop policies and conduct effective campaigns for ending gender violence, HIV and AIDS.
- Build the capacity of women and men to engage critically in democratic processes that advance equality and justice.

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gender links for equality and justice

Thohoyandou Victim Empowerment Trust

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The Violence against Women (VAW) Regional Study championed by Gender Links (GL) is a Southern African research project aimed at measuring and monitoring the extent, effect and cost of violence against women, as well as efforts to end it. GL has conducted the study in South Africa, Mauritius, Botswana, Zimbabwe and Zambia. It takes place against the backdrop of the Southern African Development Community (SADC) Protocol on Gender and Development that aims to halve levels of gender violence by 2015. GL conducted the GBV Indicators Research Limpopo study in 2012.

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Linda Musariri Chipatiso gathered and analysed the administrative data for this study and contributed in writing several chapters of this report. Machisa analysed data from the different legs of the research and coordinated the writing and editing of all the chapters in this report.

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Acronyms

AIDS	- Acquired Immune Deficiency Syndrome
ANC	- African National Congress
ARV	- Anti-retroviral drugs
BPA	- Beijing Platform for Action
CEDAW	- Convention for the Elimination of Discrimination Against Women
CEO	- Chief Executive Officer
CGE	- Commission for Gender Equality
COE	- Centres of Excellence
CSO	- Civil Society Organisation
CSVR	- Centre for the Study of Violence and Reconciliation
DAC	- District Local AIDS Council
DOH	- Department of Health
DOJ&CD	- Department of Justice & Constitutional Development
DSD	- Department of Social Development
DV	- Domestic violence
DVA	- Domestic violence Act
DWCPD	- Department of Women, Children and People with Disabilities
FCS	- Family Violence, Child Protection, Sexual Offences
FVSA	- Family Violence and Sexual Abuse
GBH	- Grievous Body Harm
GBV	- Gender based violence
GL	- Gender Links
GCIS	- South African Government Communication and Information System
GMPS	- Gender and Media Progress Study
HIV	- Human Immuno Deficiency Virus
IDMT	- Inter-Departmental Management Team
IPID	- Independent Police Investigative Directorate
IPV	- Intimate partner violence
JCPS	- Justice Crime Prevention Strategy
KZN	- KwaZulu Natal
LDOH	- Limpopo Department of Health
LDSD	- Limpopo Department of Social Development
MRC	- South African Medical Research Council
MNN	- Munna Ndi Nnyi?
NGO	- Non Governmental Organisation
NAP	- National Action Plan to end violence against women and children
NCPS	- National Crime Prevention Strategy
NICRO	- National Institute for Crime Prevention and Reintegration of Offenders
NSM SA	- National Shelter Movement South Africa
NOC	- National Operations Centre
NPA	- National Prosecuting Authority
NPO	- Non-Profit Organisation
NRSO	- National Register for Sexual Offenders
NVEP	- National Victim Empowerment Programme
OMC	- One Man Can
OVC	- Orphans and Vulnerable Children
PAC	- Provincial AIDS Council
PDA	- Personal Digital Assistant
PEP	- Post Exposure Prophylaxis
PIPV	- Perpetrator of Intimate Partner Violence
PTSD	- Post-Traumatic Stress Disorder
SADAG	- South African Anxiety and Depression Group
SADC	- Southern African Development Community
SALGA	- South African Local Governance Association
SANAC	- South African National AIDS Council
SAPS	- South African Police Services
SGVH	- Stop Gender Violence Helpline
SOA	- Sexual Offences Act
SOCA	- Sexual Offences and Community Affairs Unit
SSO	- Survivor Support Officer
STATSA	- Statistics South Africa
STI	- Sexually transmitted infections
TCC	- Thuthuzela Care Centre
TLAC	- Tswaranang Legal Aid Centre
TVEP	- Thohoyandou Victim Empowerment Programme
UN	- United Nations
UNECA	- United Nations Economic Commission for Africa
UNIFEM	- United Nations Development Fund for Women
UNWOMEN	- United Nations Entity for Gender Equity and the Empowerment of Women
VAW	- Violence against women
VEC	- Victim Empowerment Centre
VEMT	- Victim Empowerment Management Team
VEP	- Victim Empowerment programme
VCT	- Voluntary Counselling and testing
VFU	- Victim Friendly Unit
WHO	- World Health Organisation
ZTVA	- Zero Tolerance Village Alliance Project

The Management and Research Team



Colleen Lowe Morna is the GL CEO. She began her career as a journalist specialising in gender and development, coordinating the Africa office of Inter Press Service in Harare, serving as correspondent for South Magazine, as well as Africa Editor of the New Delhi-based Women's Feature Service. She served as a senior researcher on the Commonwealth Secretariat Africa desk and later as Chief Programme Officer of the Commonwealth Observer Mission to South Africa. As an advisor on gender and institutional development for the Commonwealth Fund for Technical Assistance special programme for South Africa, Lowe Morna advised on gender structures for the new South Africa and served as founding CEO of the South African Commission on Gender Equality. She holds a Master of Arts in Communications from Columbia University; Bachelor of Arts in International Affairs from the Woodrow Wilson School of International Relations, Princeton University; and a certificate in executive management from the London Business School.



Kubi Rama is GL Chief Operations Officer. She is the former CEO of the Gender and Media Southern Africa (GEMSA) Network, where she managed the financial and institutional development of GEMSA. In her earlier time as Deputy Director and Network Manager of Gender Links, she managed a new audience research project, coordinated the regional network, set up a virtual resource centre for media trainers, coordinated and sustained the 16 days of Activism, organised a regional media summit and mainstreamed gender as part of training curricula. Prior to joining Gender Links, Rama served at the Department of Journalism (Durban Institute of Technology) as a senior lecturer.



Fiona Nicholson. Born in Dar-es-Salaam in 1951, Fiona lived and worked in Zimbabwe, Hong Kong, London and the Seychelles before moving to Venda, in the far north of Limpopo, in 1982. Originally involved in tourism and entrepreneur development, she was co-opted as a business representative onto the Thohoyandou Victim Empowerment Committee established by the SAPS in 1997, in response to the National Crime Prevention Strategy promulgated at that time. The committee subsequently broke away from SAPS and was registered as the Thohoyandou Victim Empowerment Programme in January 2002. As the Founder and a Trustee, Fiona has directed the organisation for the past 14 years, and is currently focussed on securing long-term sustainability for the organisation pending her retirement. As one of the largest Community-based organisations in Southern Africa, the dedicated TVEP Team consists of 68 staff members and volunteers. Together they operate a holistic and integrated model of nine prevention, empowerment and support services for survivors, and potential victims, of sexual assault, domestic violence and child

abuse. More recently the programme has been expanded to include treatment adherence amongst HIV+ children, and HIV prevention with particular emphasis on universal access to female condoms.



Mercilene Tanyaradzwa Machisa is the GBV Indicators Research Manager. Machisa joined GL in 2010 and has managed and analysed the data from the household prevalence and attitudes surveys in South Africa, Botswana, Mauritius, Zambia and Zimbabwe. She also coordinated the implementation of the other research components and subsequent data analysis and drafted the research reports, including this Limpopo report. Prior to joining GL, Machisa worked for the National Institute of Health Research in Zimbabwe as a Medical Research Officer. Machisa also provided part time statistical consultations and support to postgraduate students in the Faculty of Health Sciences at the University of Witwatersrand. She holds a Master of Science in Medicine degree specialising in Epidemiology and Biostatistics from the University of Witwatersrand and a first class Bachelor of Science Honours degree in Biological Sciences from the Midlands State University in Zimbabwe.



Linda Musariri Chipatiso joined GL in 2013 as the GBV Indicators Research Officer. As a Hewlett Fellow, Linda recently completed her studies towards a Master of Arts degree in Demography and Population Studies from the University of Witwatersrand. She has gained significant experience in data management and analyses using household survey data from various countries in Africa. She also holds a BA Honours degree in Theatre Arts from the University of Zimbabwe. Prior to joining GL she worked as a resource mobilisation consultant at Sonke Gender Justice Network, where she focused mainly on proposal and report writing. She has also provided research consultation services to Seriti Institute, an organisation that focuses on community development in South Africa. As a demographer and population scientist, her career goal is to contribute to effective policies and evidence-based interventions that seek to address Reproductive Health, Gender and Migration issues in Africa and globally.



Ntombentsha Mbadlanyana joined Gender Links as the Gender Justice & Local Government Facilitator on the 01 March 2010. Before she joined Gender Links she had worked for the Provincial Government of the Western Cape in the Department of Social Development, Head Office and worked for the Directorate: Social Capital Formation. She is also a researcher, facilitator, gender activist and an academic with qualifications in Social Sciences. She holds a BA Degree in Women's & Gender studies as well as an Honours Degree obtained at the University of the Western Cape, majoring in Social Sciences, Anthropology, English nd Humanities. She is also studying towards completing her MA Degree in Women's & Gender Studies. After having completed her studies she worked as an intern at RAPCAN - an NGO in Cape Town that deals with the eradication of Child Abuse & Neglect. And also volunteered at the Triangle Project an organisation that deals with LGBT (Lesbian, Gay, Bisexual & Transgendered) issues.



Langanani Lenny Tshilande is a registered counsellor (PRC 0013684). She joined TVEP in 2011 October and started working as a Trauma counsellor at both Tshilidzini and Donald Fraser hospital's TVEP Trauma centres, when offering trauma counselling to GBV clients she pays much attention to sexually assaulted clients. She has also facilitated the CSVR/TVEP support group sessions in 2012 for adults SGBV clients, caring for the carers programme (Nacosa) and Gender Links "I stories"

collection and offered individual supportive intervention to participants who become emotional during the writing down of traumatic experiences. She is currently facilitating the NMCF/TVEP group healing session for children. Lenny holds Honours degree in Psychology specialising in Trauma counselling from University of Venda and currently studying part time Masters in Gender studies at Univen.



Harriet Burke (McLea) worked as a news journalist at The Times newspaper between 2009 and 2012. In this time she covered multimedia news, general news and court reporting before she took over as health reporter, focussing on human interest stories in particular. In 2011 she completed an HIV/Aids fellowship with the International Women in Media Foundation (IWMF) and in 2012 she returned as a fellow and mentored a new fellow. Her stories were shortlisted in two categories of the 2011 Discovery Health Journalism Competition. In 2012 she transferred to northern Limpopo and is now working as a freelance writer as well as an English teacher in Thohoyandou. Harriet has a certificate in Public Relations from UCT and received a B.Soc.Sci in Politics, Philosophy and Economics from the same university in 2007. She obtained a Honours degree in Journalism from Rhodes University in 2008.

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Violet Nyambo is the Monitoring and Evaluation Intern. She has worked as an interviewer in various HIV/AIDS research projects at the UZ-UCSF Collaborative Research in Women's Health Programme in Zimbabwe. Her research working experience is complemented by a master degree in Demography and Population Studies attained at the University of the Witwatersrand. She has gained extensive knowledge in qualitative and quantitative data management and analysis. She is also a 2012 Hewlett Foundation Fellow. She also holds an Honours Degree in Community Development from the University of Pretoria. Her main interests are in sexual reproductive health research namely family planning.

Foreword



Thoko Mpumlwana, Deputy Chairperson of the CGE.
Photo: Gender Links

Violence Against Women (VAW) is one of manifestations of gender inequality that remains a threat to the health and well-being of women in Limpopo and South Africa as a whole. This research comes at a critical moment in the journey towards 2015, when we take stock of what is working and what is not working in the efforts to halve levels of violence as specified in the SADC Protocol on Gender and Development.

While South Africa has taken great strides to respond to this pervasive epidemic, the statistics from this report clearly show that a lot remains to be done. South Africa has put in place comprehensive laws and policies to respond to VAW. South Africa subscribes to regional and international instruments such as the Committee on the Elimination of Discrimination against Women (CEDAW), Beijing Platform for Action and the SADC Declaration on Gender and Development. These instruments have been localised through the Domestic Violence Act (DVA), Sexual Offences Act (SOA), Employment Equity Act, Service Charter and the National Policy Statement for Victim Empowerment, all of which work towards the elimination of GBV in the country.

The GBV Indicators Research in Limpopo is the second in a series of reports on the prevalence of violence against women in South Africa. GL launched the Gauteng report in August 2011. This second edition of the GBV Indicators Research in South Africa, conducted by Gender Links, provides the comprehensive data on the situation of GBV in Limpopo. It gives an overview about the extent of GBV and what is being done to address it. More than three quarters of women (77%) have experienced violence in their lifetime. Another stark finding is that the majority of these cases do not get reported in the formal system. About half of men (48%) admit to perpetrating GBV at least once in their lifetime. Such findings underscore the need to engage the state at the national, provincial and local levels to urgently upscale the response and prevention mechanisms.

The study provides analyses of GBV from both the victim and perpetrator points of view, triangulated through an assessment of administrative data. It also gives a holistic picture of the magnitude of VAW. Highlighting the effects of GBV, it instils a sense of urgency in responsible stakeholders to act now in order to curb GBV. The research identifies the repercussions of GBV on women's health and wellbeing.

The solution to addressing the GBV pandemic is primarily about changing the mindsets of both the perpetrators and survivors of violence against women.

While the majority of participants in this study stated that both men and women should be treated equally, participants maintain a conservative approach when it comes to gender relations in the domestic sphere. Men's views remain more conservative compared to women's views in Limpopo.

The Commission for Gender Equality envisions a society free of gender oppression and all forms of inequality. The Commission undertakes research, public education, policy development, legislative initiatives, effective monitoring and litigation to achieve its mandate.

The Commission applauds Gender Links for undertaking this research. The report provides valuable insight critical to achieving the SADC Protocol's target of reducing GBV and makes a useful contribution to the ongoing discussion on how to address GBV in the region.

It is my recommendation that all relevant stakeholders treat the findings from this research as a call to amplify their strategies as they work with urgency to address GBV, not only in Limpopo, but in South Africa as a whole.

The time is now! Kenako!



Thoko Mpumlwana
Deputy Chairperson of the Commission on Gender Equality, Commissioner in charge of Limpopo Province and member of the Gender Links Board

Executive Summary



Women participate in a gender-based violence dialogue in Burgersdorp village. *Photo: Ntombi Mbadlanyana*

More than two thirds of women (77%) in Limpopo have experienced some form of gender-based violence in their lifetime, including partner and non-partner violence. About half of men, (48%) admit to perpetrating GBV at least once in their lifetime.

Most of the violence occurs within intimate relationships and is predominantly emotional - a form not usually addressed. Thirty one percent of the women experienced emotional violence while more than a third of men (36%) perpetrated emotional Intimate Partner Violence (IPV) in their lifetime. Women experience and men perpetrate other forms of intimate violence including physical, sexual and economic violence. Almost a quarter of women (23%) and a quarter (25%) of men reported physical IPV experience and perpetration respectively. Thirteen percent of women and 14% of men reported econo-

mic IPV experience and perpetration respectively. Seven percent of women experienced and 12% of men perpetrated sexual IPV. One in every five women (21%) reported abuse during at least one of their pregnancies. In the majority of cases, women and men reported multiple incidents of physical or sexual IPV.

Thirteen percent of women and one in every five (20%) men reported IPV perpetration in the 12 months before the survey. Similar to the lifetime prevalence trends, emotional IPV is the most common form reported by women (10%). However economic IPV is the second highest (7%) followed by physical IPV (6%) and lastly sexual IPV (3%). Unique to this study is that for all forms of IPV, a greater proportion of men reported perpetration compared to the proportion of women that reported experiencing violence.

Despite such high prevalence of VAW, the majority of women survivors do not report violence to the police or seek help and many women do not seek help from health care facilities. Only one in eight women who had been physically abused by intimate partners reported it to the police. A lower proportion of women - one in 10 - sought medical attention after physical abuse. One in 15 women interviewed had obtained a protection order against a physically abusive partner.

Five percent of women reported non-partner rape while almost five times as many men (23%) reported perpetrating non-partner rape. Only one in every eight women who had been raped reported it to police. About one in every five women who had been raped sought medical attention. This finding is consistent with studies conducted in Gauteng and other SADC countries where research shows similar underreporting of non-partner rape and physical IPV.

Inspired by the Southern African Development Community (SACD) Protocol on Gender and Development, that aims to halve gender violence by 2015, the study is the second standalone, provincially representative and comprehensive community-based research study of its kind. It looks at the prevalence of gender violence in the Limpopo province of South Africa.

The GBV Indicators Research in Limpopo measured GBV experience and perpetration, gender attitudes, selected health-related behaviour and exposure to prevention campaigns among women and men in Limpopo. The study looked at intimate partner violence (IPV) including physical, sexual and emotional violence, non-partner rape and sexual harassment. It presents findings in five categories: the extent; patterns and drivers; effects; responses; support and prevention of VAW.

The flagship prevalence and attitudes survey employed two separate questionnaires for women (focusing on their experiences) and men (focusing on perpetration) of violence. In addition to the prevalence survey, tools used include interrogating administrative data (like police, court and shelter statistics); qualitative research; a costing exercise; political discourse analysis; and media monitoring. The study triangulates the research from the different methods to strengthen the survey findings. Together these establish a range of baseline indicators on gender violence for the country.

Individual relationship, community and societal factors can be associated with GBV experience or perpetration. The incidence of GBV in Limpopo is exacerbated by socio-demographic factors, patriarchal societal norms of legitimacy of male dominance and control; wife ownership, sexual entitlement in marriage, men's experience of child sexual abuse and intake of alcohol.

GBV has negative repercussions on women's health and wellbeing. These include physical injury, poor mental health, unplanned pregnancies, stigmatisation, loss of days from work, Sexually Transmitted Infection (STI) symptoms, increased risk to HIV and out-of pocket expenses. Because women constitute a higher proportion of GBV survivors, they also bear the higher costs among the survivors.

Despite these conspicuous violations of women's rights, South Africa has implemented progressive and comprehensive laws, policies and support systems to respond to GBV. Some of the regional and international instruments adopted by the country

include the CEDAW, SADC Declaration on Gender and Development and the UN Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power. These instruments have been localised, giving rise to the Domestic Violence Act (DVA), Sexual Offences Act (SOA), Employment Equity Act, Service Charter and Minimum Standards for Victims of Crime in South Africa and the National Policy Statement for Victim Empowerment, all of which work towards elimination of GBV in the country.

Although South Africa enacted the Domestic Violence Act in 2007, lawmakers need to implement more efforts to ensure that the public is aware of it and that it is effectively implemented. Just one in five men and one in 10 women had heard of the 16 Days of Activism Campaign. A lower proportion of women (6%) and men (16%) knew about the 365 Days Campaign. Three percent of women and almost a quarter of men (23%) had participated in a march or event to raise awareness about GBV. Men in the province seem to have more access to information about campaigns. These findings provide evidence of a need for greater outreach efforts in GBV campaigns.

The national Victim Empowerment Programme (VEP) has facilitated the establishment and integration of inter-sectoral programmes and policies for the support, protection and empowerment of victims of crime and violence with a special focus on women and children. Police have established VEP centres in police stations across Limpopo province. The number of available structures, however, is outnumbered by the number victims. There is a shortage of shelters for abused women. Even fewer second and third stage shelters exist, leaving women who leave first stage shelters with nowhere to go. This is exacerbated by adverse economic conditions faced by many women in the province. A woman leaving a shelter often has few, if any, options other than to go back into an abusive relationship.

Several integrated approaches exist that involve both government and civil society in dealing with the prevalence of GBV at national and provincial levels. These include the National GBV council, the 365 Day National Action Plan (NAP), the Integrated Victim Empowerment Policy (IVEP) and the Thuthuzela Care Centres (TCC). Despite these structures, incidence of GBV remains widespread and many survivors do not access TCCs or the one-stop centres that form part of the VEP programme.

Challenges in operating and implementing these integrated structures and policies include lack of funding, poor coordination among structure members and poor monitoring and evaluation systems. Other issues include the inadequacy and ineffectiveness of some of the structures, including the TCCs, which refer less than half of the cases to the courts. This can act as a deterrent for survivors who might access these services. National conviction rates for sexual offences have also decreased.

Recommendations

The GBV Indicators research has found high rates of GBV in the province. Much of the violence is occurring within the domestic sphere, with emotional intimate partner violence most dominant. Perhaps most alarming is the low rate of reporting to police and health departments. The study also found that men are more likely to disclose perpetration than women disclose experience of VAW. It is imperative that further research looks into the reasons for this finding. GBV campaigns need to empower women and encourage them to speak out and seek help. In addition, future research is needed to establish the determinant factors that fuel violations of women's rights in the province.

Patterns and drivers

GBV prevention campaigns need to consider and target the identified risk groups. Limpopo has the highest recorded rates of sexual violence in the workplace. Therefore workplace-based initiatives will go a long way in targeting those men who could be perpetrators of GBV. There is also a need for child rehabilitation programmes for abused children coupled with campaigns advocating for reduction of child abuse. Prevention of child abuse may ultimately contribute to prevention of VAW perpetration.

Women and men in this study exhibited conservative attitudes towards gender relations, which is another driver of GBV. Thus there is a need to engage not only men, but also women, girls and boys, especially from a younger age when they can be socialised to comprehend gender equality. Campaigns should aim to change conservative attitudes towards gender relations and should encourage communities to be more supportive of GBV survivors. The government should also continue streamlining the education curriculum from primary level to include the teaching of positive gender attitudes that promote a culture that does not tolerate violence against women.

Response

Data on GBV from the Department of Health, the South Africa Police Service (SAPS) and the Department of Justice and Constitutional Development (DOJCD) is not disaggregated by age, sex or type of GBV, as well as the number of cases withdrawn by women. Some of the challenges impeding the goal of eliminating violence include lack of dedication and efficiency by key role players in the criminal justice system. This is illustrated in several personal accounts from survivors detailing negative experiences with police. Personnel who deal with victims and survivors of violence need further training.

Support

Limpopo does not have enough shelter services to cater to the number of VAW survivors. Government should allocate more resources to existing shelters and for the establishment of new shelters, especially second and third stage shelters.

Both women and men are relatively unaware of the DVA and provisions for protection orders. Public awareness campaigns should aim to sensitise communities about the DVA and GBV-related laws. Administrative data falls short in depicting the true extent of GBV within the Limpopo province. The government should adopt the GBV Indicators Study research methodology and commit to allocating resources for periodic GBV studies and dedicated surveys that provide information about GBV at the national level.

Prevention

Because women and men do not know about GBV campaigns there is a need to increase focus on awareness-raising campaigns, especially for women. Campaigns can also use the television and radio to accomplish maximum outreach. However, there is also a need to accelerate efforts in disseminating knowledge in other ways, including via community mobilisation and print media.

Integrated approaches

It is necessary to increase funding and staff allocation within the different structures working with victims of GBV. More training for personnel is also a prerequisite for effective functioning of the integrated approaches.

CHAPTER 1

BACKGROUND AND CONTEXT OF VIOLENCE AGAINST WOMEN



A commitment pledge ceremony and launch of the local AIDS Council in Aganang district of Limpopo. *Photo by Ntombi Mbadlanyana*

Key facts

- The SADC Protocol on Gender and Development sets a target for SADC member states to halve GBV by 2015.
- Although previous research indicates that GBV is a flagrant violation of human rights in Limpopo province and the country at large, there is lack of recent comprehensive and provincially representative data on its extent, causes and effects, as well as on the response to it and the impact of prevention interventions.
- While various studies investigated the underlying causes of GBV in other provinces of South Africa, there is a need to establish indicators for measuring GBV and enhance the body of knowledge pertaining to the scourge of VAW within the Limpopo provincial context.
- GL implemented this study to fill this critical information gap.
- This study is the second provincially representative study in the province, following the 1999 MRC Three Provinces Study.
- The study tools and methodology used have been employed in Gauteng province in 2010, as well as in KwaZulu Natal and Western Cape. Similar studies have also been conducted on a national scale in Botswana, Lesotho, Mauritius and Zimbabwe.



I (Ambani) am a 36-year-old woman. My boyfriend came to stay with us in 2003. My husband died in 2000. When my husband passed away I had a son. In 2002, I then had a second child, a baby girl. Initially things were well because my boyfriend cared for me and my children.

I also did not know at the time that he drinks alcohol and smokes cigarettes, because he hid it from me.

At some point he changed and became so controlling. He would not allow me to visit family and friends. He also prohibited other people from visiting me. If someone came to the house he would ask who they were and what were they looking for. If the visitor was a man then it became a big problem for my boyfriend.

Even if a car turned near our yard, I would have to explain whose car it was and why it was turning at my gate. It was annoying to have to explain everything to him because I was not used to that. I felt that he had no right to ask me those questions because it was not his house - it was mine.

The first day he beat me I felt like I was dreaming. It felt like it didn't happen. When I asked him, "Why are you beating me?" he said that I was too clever and thought I could fool him.

Then it became worse, because he started coming home drunk. When I asked him about the drinking, he stopped hiding his habit from me and started drinking at shebeens near my house.

At that time the children were sleeping in a hut that we used for cooking because there wasn't enough space in the house. I decided that it would be better for us to build another room. Gwala, my boyfriend, refused for my children to move into the new room when it was complete. He said that they would make too much noise. When they wanted to watch television, it was always a fight with Gwala. This pained me because I bought the house and the building materials for the new room alone. Gwala had changed and this was even more painful for me. I couldn't recognise the man I had first met. I wondered if he was the true Gwala that I thought I knew.

Then I started having problems with my son. He was always scared and was crying easily. He spent most of his time away from home. On Fridays he went to stay with his grandmother so that he would be able to go out to visit friends for the weekend. Even myself, I was always scared. I couldn't even tell Gwala that my son was going to visit his grandmother.

I really became angry when Gwala told my son that he would beat him. He always blamed my children whenever something went wrong at my home. He stopped calling my children by their real names and called them names.

My children were no longer performing well at school and started failing, which was painful for me. When I went to tell my relatives they said, "There's nothing we can say because you are the one who loved him and brought him into your house. So it's up to you."

Being beaten became an everyday thing. My neighbours found out when they saw him beating me. They came to try to ask what was going on. When it was late at night my neighbours would take my children and give them a place to sleep.

After the violent incidents, Gwala would always apologise and promise it won't happen again. However, when he got drunk he would do the same thing again. When he wasn't drunk he was a very good person. You might think that I was lying about his bad qualities.

I went to the police several times and it didn't work. They gave me a protection order but he didn't follow it, he violated it and the police would arrest him. Gwala would come back home without even spending a week in prison. This really hurt me.

I felt like waking up and killing him while he was sleeping. I remember telling my father that I was going to come up with a plan to punish him myself because I was not getting any help from the system. But my father advised me against it.

Ambani has experienced violence at the hands of an intimate partner. He regularly beat her and stopped her from visiting friends or being visited. He questioned any visits she received, especially from male visitors. Because of this her children suffered emotionally and their school work suffered. Her son even stayed away from home on weekends. Ambani felt helpless because her partner ignored protection orders. Her family blamed her for allowing a boyfriend to move in after her husband died.

This report outlines the background, methods and findings of the GBV Indicators research in Limpopo province of South Africa conducted by GL in partnership with TVEP. More specifically, the first chapter outlines the regional background and rationale for the GBV Indicators research in Limpopo, its unique features, country context and previous related research.

Background and rationale



Gender-based violence (GBV), particularly VAW, continues to be one of the most common and serious human rights violations occurring in the SADC region. In response to the high levels of violence, and the 2006 call by the UN Secretary General to all member states to develop plans for ending such human rights violation, many Southern African countries have shifted from campaign mode to a more integrated programmatic approach in addressing GBV.

GL has been working in the gender justice arena for 11 years, using the 16 Days of Activism on Violence against Women as a platform for training activists in the SADC region in strategic communications. These campaigns led to inevitable questions about the sustainability of such campaigns beyond the 16 Days. In 2006, GL began working with nine countries in the SADC region to extend the 16 Days to a 365 Day National Action Plan strategy to end gender violence.

Developing action plans inevitably led to the need for reliable baseline data, targets and indicators for measuring progress in an arena where most violence is underreported or not reported at all, which means administrative data is an unreliable source of information.

In August 2008, SADC heads of state adopted the Protocol on Gender and Development that, among others, aims to halve gender violence by 2015. The question that arises following this key step is how governments will know if this target is being achieved if we do not know the starting point. To measure the efficacy of both government and civil society programmes, there is a need to have baseline data on the extent and effects of VAW, as well as the manner in which governments and civil support organisations respond to VAW. This underpins the innovative GBV Indicators research conducted in Botswana, Lesotho, Mauritius, South Africa, Zambia and Zimbabwe by GL, in association with various local stakeholders.

Drawing on the 2007 UN Expert Group Report on developing indicators for measuring GBV, some preliminary work began in earnest in Southern Africa through an initiative supported by UN Trust Fund and spearheaded by GL. The key players included representatives of government (i.e. gender, justice, health, police and prosecuting authority), research institutes and NGOs working on gender justice issues.

The UN Economic Commission Africa Gender Centre (UNECA/AGC) commissioned desktop research for the rest of Africa following similar methods used by GL and partners for the pilot project. The Centre for the Study of Violence and Reconciliation found gaps in the data collected by many different countries on GBV by looking at administrative data collection and situational analysis. Some countries do not even have recording systems on any aspect of VAW. Laws in various countries do not regard certain acts of GBV

as punitive violations, thus making it difficult for countries to speak the same messages on GBV This is taking place despite the fact that lawmakers in most countries unanimously agree that GBV is a gross violation of human dignity and have made demonstrable strides in combating its existence, mainly through ratification of tools such as the SADC Protocol on Gender and Development.



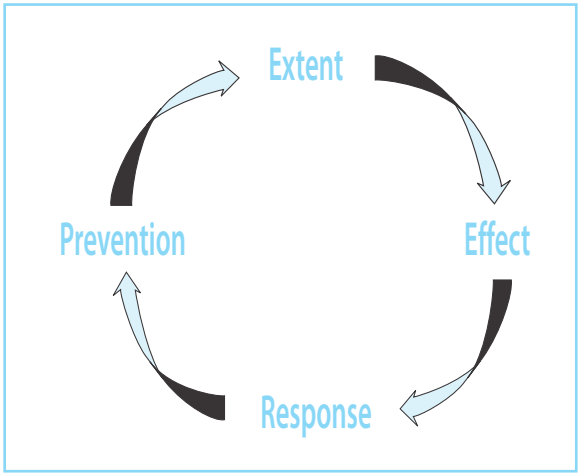
A 2009 think tank meeting helped determine key indicators that can be used to measure the extent of GBV in Southern Africa. *Photo by Gender Links*

The work of developing a set of indicators to measure GBV included a UNIFEM funded expert group think tank meeting from 10-11 July 2008. Sixteen representatives from government, research organisations and South African and regional NGOs focusing on gender and gender violence issues participated. This meeting sought to get conceptual clarity on requirements, as well as buy-in from key stakeholders, for developing a composite set of indicators to measure gender violence that is methodologically solid, pre-tested, and can eventually be applied across the region.

The meeting aimed to determine indicators that can be used to measure the extent of the problem (what uniform administrative and survey data could be obtained across all countries); the effect of the problem in social and economic terms; the response and support interventions as measured by the multi stakeholder National Action Plans to End Gender Violence based on the SADC Addendum and draft Protocol on Gender and Development; and the prevention interventions that underscore the importance of a paradigm shift towards prevention rather than simply response mechanisms.

Key conceptual decisions taken at the meeting included the need to incorporate GBV as experienced by both women and men; to interrogate existing administrative data much more closely; to use prevalence studies to determine the extent of under-reporting and rarely reported types such as emotional and economic abuse; to combine prevalence and attitude studies and to facilitate more in-depth interrogation of data, for example on whether links exist between being a survivor/ perpetrator and various kinds of attitude/behaviour.

The team emphasised the need to test a draft set of indicators in a pilot project at local level before these are cascaded nationally and regionally. This study would gradually build support and buy-in for a comprehensive set of indicators that provides meaningful and nuanced measures of progress or regression.



Unique features of the project

Unlike previous prevalence surveys that have focused on a few aspects of VAW, the set of indicators seeks to measure:

- The extent of the problem (what uniform administrative and survey data could be obtained across all SADC countries);
- The social and economic effects of VAW;
- Response and support interventions as measured by the multi stakeholder National Action Plans to End Gender Violence based on the SADC Protocol on Gender and Development; and
- Prevention interventions that underscore the importance of a paradigm shift towards prevention rather than focus primarily on response.

GBV reference group report and process

GL convened an inception and reference group meeting in May 2012 in Polokwane. The meeting's objectives included sharing the project overview, briefing participants on how to do the research, obtaining stakeholder buy-in, obtaining recommendations for project implementation and finalising the research tools.

Participants included representatives from the National Prosecuting Authority (NPA), SAPS, GL, Polokwane Municipality, Office of the Premier, University of Limpopo, South African Local Government Association (SALGA), Department of Health (DOH), Irish Aid, Lawyers for Human Rights, Department of Social Development (DSD), Victim Empowerment Programme (VEP) centres, Far North Network on Family Violence, Lebowakgomo FM, Munna Ndi Nnyi, Tshilidzini TCC and the Capricorn District.

Country context

South Africa is known for its high levels of crime, stemming from a history of interpersonal violence linked to conflict and political struggle.[1] The leading cause of death and reduction in quality of life, also known as lost disability-adjusted life years, is due to violence and injuries from it.[2] Common crimes perpetrated against women include intimate partner violence, rape and femicide (Jewkes et al, 1999; Jewkes et al, 2006; Dunkle et al, 2004; Mathews et al, 2008).



South Africa is signatory to several conventions to combat VAW, including the Convention on the Elimination of Discrimination against Women (CEDAW), the Beijing Platform for Action (BPA); and the Protocol to the African Charter on Human and Peoples Rights on the Rights of Women in Africa.

South Africa has also committed to the provisions of the SADC Gender and Development Protocol of 2008. The Protocol objectives aim to empower women, to eliminate discrimination and to achieve gender equality and equity through the development and implementation of gender-responsive legislation, policies, programmes and projects.

The following table outlines South Africa's progress in implementing the provisions of the different instruments.

[1] www.statssa.gov.za
[2] Seedat et al 2009

Table 1.1: South Africa's progress against different instruments		
Instrument	**State responsibility**	**Progress made**
CEDAW	1. Provide support services for all survivors of gender-based violence, including refugees, specially trained health workers, rehabilitation and counselling services.[3]	• Mechanisms have been established to address the needs of survivors, including one-stop centres with counsellors, police and legal officers. • Stakeholders have established a 365 day national action plan to address GBV. • There is a progressive legal framework that ensures the protection of women rights. • Police and prosecutors receive training to address issues of sexual violence. • Legislation includes: a) Domestic Violence Act, 1998 (Act 116 of 1998); b) Sexual Offences Act, 1957 (Act 23 of 1957); c) Criminal Law (Sexual Offence and related Matters) Amended Act, 2007 (Act 32 of 2007); d) Employment Equity (Act No 55 of 1998). • Strategies and programmes developed include: a) The Anti-Rape Strategy (prevention, reaction and support) developed by an interdepartmental Management Team as an integrated response on violence against women; b) Domestic Violence Programme (prevention and reaction); c) Child Abuse and Neglect programme (prevention and reaction); d) Interdepartmental initiatives to improve Criminal Justice System processes for Rape and Sexual Offences (e.g. Multi-Disciplinary Service Centres, specialised training, Sexual Offences Courts, Family Violence, Child Protection and Sexual Offences (FCS) Units); e) Communication, Education and Awareness programmes; and f) Local and community-based programmes (community policing, neighbourhood watches). g) Communication, Education and Awareness programmes commissioned. • Inter-Departmental Management Team (IDMT) implemented at government level to coordinate an integrated response to violence against women. • More recently in 2012, the DWCPD inaugurated the National Council Against GBV.
	2. Use "due diligence" to prevent, prosecute and punish perpetrators who commit violence against women.	
	3. Collect data on violence against women.	
	4. Sensitise members of the criminal justice system.	
Beijing Declaration and Platform For Action - (1995)	1. Enact legislation on preventing and addressing issues of violence against women and girls.	
	2. Put in place strategies to address survivors of violence, as well as strategies with punitive measures against perpetrators of violence against women.	
SADC Gender and Development Protocol 2008	1. Enacting and enforcing prohibitive legislation.	
	2. Eradicating social, economic, cultural and political practices and religious beliefs that legitimise and exacerbate the persistence and tolerance of gender-based violence.	
	3. Adopting integrated approaches, including institutional cross-sector structures, with the aim of reducing current levels of violence by 50%.	
	4. Ensure implementation, monitoring and evaluation of these abovementioned efforts.	

[3] Commission on Human Rights, 1996.

Although stakeholders have implemented relevant systems there is need for more vigilant data collection and management. There is also need for a comprehensive set of indicators to evaluate progress. In conducting this research, GL is testing a set of indicators which can be used as baseline and to monitor GBV programmes.

The GBV Indicators research implemented by GL is mainly focused in achieving Article 25 of the SADC Protocol on Gender and Development relating to adopting integrated approaches with the aim of reducing current levels of GBV by 50% by 2015. It is the role of the signatory governments to ensure implementation, monitoring and evaluation of these abovementioned efforts.

Legislation and the criminal justice system

South Africa has enacted protective laws to address issues of VAW. Lawmakers implemented the Domestic Violence Act No. 116 of 1998 in 1999. The Act seeks to protect women, men and children against violence, regardless of sexual orientation. A study conducted to monitor the impact of the DVA on the lives of women from 1999 to 2009 found a 40% increase in protection orders against non-intimate partners or by men against women (Mathews & Abrahams, 2001).

The Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007 (Act No. 32 of 2007), came into operation on 16 December 2007. It expanded the definition of rape to encompass rape of men and use of any object in sexually assaulting another person.

Integrated Approaches

Prior to the SADC Protocol, South Africa had made advances through the development of a 365 Days Action Plan to end Violence Against Women and children. In March 2007, South Africa adopted the 365 Day National Action Plan for Ending Gender Violence, driven by the sexual offences unit of the National Prosecuting Authority Sexual Offences and Community Affairs Unit (NPA SOCA). The plan was an expansion of the efforts observed in the 16 Days of Activism against GBV and it came about through multi-sectoral partnerships between government and civil society organisations. The key focal areas of implementation include legal, social, economic, cultural and political services; awareness, education and training; integrated approaches; and budgetary allocations.

The National Council Against GBV

Deputy President of the Republic of South Africa Kgalema Motlanthe inaugurated the Council on 10 December 2012 as a direct response to the issues raised at CEDAW following South Africa's country report in 2011. The role of the council is to elevate the multi-sectoral intervention approach to a strategic level and monitor the implementation of all programmes dealing with GBV in the country, including the 365 Days action plan.

Previous research

Intimate partner violence

Intimate partner violence is a prevalent feature of intimate relationships and is a widely acknowledged norm (Jewkes, 2002; Wood and Jewkes, 1998). Forms of violence identified through previous research include emotional or psychological, economic, physical and sexual intimate partner violence (Jewkes et al, 2006; Dunkle et al, 2004a; Jewkes et al, 2003; Jewkes et al, 1999;). The extent of the problem has been variable is the differing studies, which can be explained by the differing study and sampling designs. The patterns of violence and exacerbating factors have also differed by site.

There is evidence that South Africa also has some of the highest levels of physical IPV in the region. More than a quarter (28%) of men participating in the South African Health and Stress Study reported having used physical violence against their current or most recent female partner during their current or most recent marriage or cohabiting relationship (Gupta et al, 2008). Other studies based on male samples found that one in four men had been violent towards a female partner (Jewkes, Sikweyiya, Morrell, et al, 2009; Gupta et al, 2008). One in four women interviewed in the *Three Provinces Study* reported having experienced physical abuse by a male intimate partner (Jewkes, Levin, & Penn-Kekana, 2003). Dunkle et al (2004a) found that 25.5% of women had experienced physical

abuse by an intimate partner in the 12 months preceding the interview and more than half did so in their lifetime.

Since the *Three Provinces Study* conducted in Mpumalanga, Eastern Cape and Limpopo province (then named Northern Province) by the Medical Research Council (MRC) in 1998, there have been no further studies on the prevalence of GBV among women in a community with a representative sample of women in the population (at least none that has used reliable methods and thus provided robust prevalence estimates). The research used a cluster sampling methodology to draw a randomly-selected sample of women in the province. Researchers interviewed one randomly selected woman between the ages of 18-49 in each selected household: a total of 1306 women in the three provinces: 403 in the Eastern Cape, 428 in Mpumalanga and 474 in the Northern Province.

The key findings of the MRC study can be found in a report entitled *"He must give me money, he mustn't beat me", Violence against women in three South African Provinces* and associated articles. The findings include:[4, 5, 6]

Table 1.2: Findings of the *Three Provinces Study*

Indicator	Eastern Cape	Mpumalanga	Limpopo (formerly Northern) Province
Percentage women ever physically abused by a partner	26.8	28.4	19.1
Percentage women experiencing partner physical violence in the past year	10.9	11.9	4.5
Percentage women ever raped	4.5	7.2	4.8
Percentage women whose partner had ever boasted about or brought home girlfriends	5	10.4	7
Percentage of women physically abused during pregnancy	9.1	6.7	4.7
Percentage of women experiencing physical abuse who had been injured in the previous year	34.9	48	60
Percentage of women who had experienced emotional or financial abuse in the previous year	51.4	50	39.6
Estimated number of women treated in health facilities for injuries from partner violence per year	121 000	74 294	93 868
Estimated number of days lost from employment due to partner violence per year	96 751	178 929	197 392
Estimated number of days spent in bed due to injury after abuse per year	480 709	154 184	263 871

The study concluded that:

- Emotional, financial and physical abuse is common in relationships and many women have been raped.
- Physical violence often continues during pregnancy and constitutes an important cause of reproductive morbidity.
- Many women are injured by their partners and the health sector expends considerable resources on providing treatment for these injuries.
- Injuries result in incurred costs in other sectors, notably to the family and the women's community and employers and the national economy.

[4] Jewkes R, Penn-Kekana L, Levin J, Ratsaka M, Schrieber M (1999) "He must give me money, he mustn't beat me" Violence against women in three South African Provinces. Medical Research Council Technical Report, Pretoria.
[5] Jewkes R, Penn-Kekana L, Levin J, Ratsaka M, Schrieber M. Prevalence of emotional, physical and sexual abuse of women in three South African Provinces. South African Medical Journal 2001; 91(5):421-428.
[6] Jewkes R, Penn-Kekana L, Levin J. Risk factors for domestic violence: findings from a South African cross-sectional study. Social Science and Medicine 2002; 55, 1603-1618.

The Medical Research Council's *Three Provinces Study* showed gaps in the proportion of women reporting rape and women reporting rape to police stations around the country (Jewkes et al, 1999). It found that 1300 women aged 18-49 for every 100 000 had been "physically forced" to have sex (Jewkes et al, 2001) and in the same year, 210 of every 100 000 women reported being raped to the police (SAPS, 1999). These rates show that at most one in nine cases is reported to the police.

War at Home - Gauteng

This study is the first comprehensive community-based research study on the prevalence of GBV in the Gauteng province and South Africa. Gender Links and the Medical Research Council (MRC) conducted the study. It employed the same methodology tools used for this study. More than half of women in Gauteng (51%) have experienced some form of violence (emotional, economic, physical or sexual) in their lifetime and 78% of men in the province admit to perpetrating some form of violence against women. Only 4% of women interviewed reported these crimes to police. One in 13 women reported non-partner rape and overall only one in 25 rapes had been reported to the police. Following the research, SAPS agreed to four key ways to improve collection of domestic violence data. These include adding the nature of the relationship to records of domestic violence; creating a category for femicide; removing pornography and sex work from sexual offences statistics, as this masks the true nature, trends and patterns of sexual offences; and including a section on domestic violence.

Femicide

South Africa has a rate of intimate femicide-suicide, (when a woman is killed by an intimate partner who then commits suicide) that exceeds reported rates for other countries. The 1999 *Intimate Femicide-Suicide in South Africa: A Cross-Sectional Study* examined the incidence and patterns of intimate femicide-suicide and described the factors associated with an increase in the risk of suicide after intimate femicide (the killing of an intimate female partner).[7] Researchers conducted a cross-sectional retrospective national mortuary-based study at a proportionate random sample of 25 legal laboratories to identify all homicides committed in 1999 of women aged more than 13 years.

Researchers collected data from the mortuary files, autopsy reports and police interviews. Among 1349 perpetrators of intimate femicide, 19.4% committed suicide within a week of the murder. The number of women killed is six times the global average and half of all women had been murdered by an intimate partner. Suicide after intimate femicide is more likely if the perpetrator is white. Guns play a factor - 91.5% of the deaths of legal gun-owning perpetrators and their victims may have been averted if this group of perpetrators did not own a legal gun. This study highlights the public health impact of legal gun ownership in cases of intimate femicide-suicide.



Photo courtesy of Google Images

Exacerbating factors

GBV is a by-product of gender inequality in South Africa, which remains patriarchal. Underlying factors associated with experience of GBV include male control of women and unequal power and gender relations in intimate relationships (O'Sullivan et al, 2006; Wood et al, 1998; Langen, 2005; Pettifor et al, 2004b; Jewkes et al, 2003; MacPhail & Campbell, 2001, Dunkle, 2004b). Men's control over women is seen

[7] Intimate femicide-suicide in South Africa: a cross-sectional study, Shanaaz Mathews, Naeemah Abrahams, Rachel Jewkes, Lorna J Martin, Carl Lombard & Lisa Vetten.

as a mark of masculinity. Culture, religion and media reinforce these norms and promote the view that men should be in power within homes and public institutions while women should be in a position of subservience.

Male perpetration of violence against women is also associated with exposure to violence during childhood (Jewkes et al, 2009; Gupta et al, 2008; Abrahams and Jewkes, 2005), which in turn is associated with men's later involvement in physical conflicts in their community or workspaces, the use of physical violence against their partners and arrests for possession of illegal firearms (Abrahams and Jewkes, 2005).

Effects

The effects of gender-based-violence manifest in a number of different ways and these are particularly evident in women. Health consequences mentioned by South African women who reported GBV include varying forms of physical and mental health problems such as unplanned pregnancies, sexually transmitted infections, posttraumatic stress disorder (PTSD), depression physical injuries, mental illness and HIV infection (Dunkle et al, 2004b, Campbell, 1998; Campbell, 2002; Deblinger, McLeer, Atkins, Ralphe, & Foa, 1989; Decker, Silverman, & Raj, 2005; Foa, 1997; Moser, Hajcak, Simons, & Foa, 2007; Petersen et al., 1997; Silverman, Decker, Reed, & Raj, 2006; Silverman, Raj, & Clements, 2004).

Provincial context

Limpopo is situated at the north-eastern corner of the Republic of South Africa. The province is divided into five districts: Waterberg District Municipality, Capricorn District Municipality, Vhembe District Municipality, Mopani District Municipality and Sekhukhune District Municipality. These five districts are subdivided in 24 local municipalities.

The population of Limpopo comprises several ethnic groups but is predominantly Pedi followed by Tsonga, Venda, Afrikaner and English. Because Limpopo province shares international borders with districts and provinces of three countries - Botswana's Central and Kgatleng districts to the west and north-west respectively, Zimbabwe's Matabeleland South and Masvingo provinces to the north and northeast respectively and Mozambique's Gaza Province to the east - it also has a significant proportion of foreign migrant workers.

Why this research?

The MRC conducted the *Three Provinces Study* in Mpumalanga, Eastern Cape and the (then named) Northern Province in 1998. It also partnered with GL to conduct the Gauteng GBV Indicators research. However, there has been no study on the prevalence of GBV among women in a community with a representative sample of women and men across the more rural Limpopo province.

GL's GBV Indicators research provides the second ever population-based prevalence data on women in Limpopo and comparative data in the form of reports on perpetration by men. It encompasses the extent, effects, response, support and prevention of GBV, as well as awareness of legislation and services available to the survivors. The research provides important insights into the prevalence of GBV and perpetration of sexual violence in Limpopo province of South Africa.

Table 1.3: District municipalities of Limpopo province

Capricorn District	Mopani District	Sekhukhune District	Vhembe District	Waterberg District
Aganang	Ba-Phalaborwa	Elias Motsoaledi	Makhado	Bela-Bela
Blouberg	Greater Giyani	Fetakgomo	Musina	Lephalale
Lepele-Nkumpi	Greater Letaba	Ephraim Mogale	Mutale	Modimolle
Molemole	Greater Tzaneen	Greater Tubatse	Thulamela	Mogalakwena
Polokwane	Maruleng	Makhuduthamaga		Mookgopong
				Thabazimbi

CHAPTER 2
SCOPE AND METHODOLOGY



A GBV research indicators stakeholder planning meeting in Polokwane, Limpopo. *Photo by Ntombi Mbadlanyana*

Key facts

- The GBV Indicators research in Limpopo measured VAW experience and perpetration, gender attitudes, selected health-related behaviour and exposure to prevention campaigns among women and men.
- GL conducted a prevalence and attitudes household survey based on a two-stage cluster random sampling strategy.
- The survey comprised women and men aged 18 years and above.
- GL collected and analysed available administrative data from the province.
- TVEP co-facilitated the collection of the "I" Stories or first-hand accounts of VAW experiences from the province.
- GL collected political speeches given during the period 2011-2012, dissected and analysed them in order to assess how often politicians mentioned VAW, who mentioned it and to what audience.
- GL triangulated the findings from the different methods to strengthen the survey findings.



On 7 March 2012, I (Mulalo) was coming back from a spaza shop where I had bought bread. Next to a mango tree I saw a man, who grabbed me and covered my mouth and eyes. In an attempt to free myself we started fighting. However, I became tired and he defeated me. He told me that he wanted to rape me and if I didn't let him then he would kill me. I felt that it was better to be raped than to be killed.

He tied my hands with shoe laces and he put a piece of cardboard in my mouth. He then opened my legs and started raping me. I was crying silently until he finished with me. He untied me and he began to talk to me nicely. When I looked at him I realised I didn't know who he was at all. He ran away and I started screaming.

People in a house close by came out and started looking for him but they couldn't find him. They accompanied me home. When I got home my sister said that in the morning she would take me to Vhufuli Hospital.

When I got to the hospital they told me that I should start at the clinic so we went there and were given a letter that I had to take to the trauma centre. When I got there I was helped by two women who were asking me what happened and at what time. They called the police so that I could open a case. They took me inside the hospital for a doctor to examine me. I had an HIV test and they gave me medicine and counselled me.

Until now I still don't know the person who raped me. I have a problem that the police are not finding him and if he got arrested I would be very happy so that he could feel the pain that I am feeling. I got help from my parents and my sister. They told me to accept it because I am not the first person in life to go through such and there are many people who are experiencing things that are even worse than being raped. "Just thank God that He protected you because if that man had a weapon he would have killed you," they said.

Mulalo's story epitomises the circumstances and effects of rape in South Africa. She is raped by a stranger under threats of death. Like many victims of rape, she is forced to choose life at the expense of her dignity. Through a supportive family and community, Mulalo manages to accept what befell her, marking the beginning of her healing process. However, like many victims, she lives with the wish to see her rapist held responsible for the crime.

This chapter outlines the project aim, key research questions and methods employed in this study to measure the different forms of VAW, including rape. The five tools provide several different prisms from which to view VAW. The use of several tools - quantitative and qualitative - reflects the complexity of the subject and the need for more than one tool to triangulate, interrogate and interpret the data in ways that strengthen policy-making and action planning.

Working definition

The 1993 UN Declaration on the Elimination of GBV defined GBV as "any act which 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 deprivations of liberty, whether occurring in public or in private life."[8] It indicated that this definition encompassed, but was not limited to:

- Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;
- Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation

[8] Cited in (2008), Population Council, "Sexual and Gender-based Violence in Africa - A literature review", available at: http://www.popcouncil.org/pdfs/AfricaSGBV_LitReview.pdf

at work, in educational institutions and elsewhere, trafficking in women and forced prostitution; and
- Physical, sexual and psychological violence perpetrated or condoned by the state, wherever it occurs.[9]

For the purposes of this study GBV is used interchangeably with VAW and it comprises:
- Physical, sexual, psychological and economic intimate partner violence;
- Rape and sexual assault by a partner, stranger, acquaintance or family member, experienced by adults and in childhood; and
- Sexual harassment.

Project aim



Inspired by the SADC Protocol, which sets a target to reduce the current levels of GBV by 50% by the year 2015, this study seeks to test the GBV indicators developed through expert consultation, and provide extensive data of GBV in Limpopo province of South Africa. The GBV Indicators research in Limpopo province will contribute to the reduction of GBV by providing data to be used to monitor and evaluate the efforts of government and civil society to halve the current levels of VAW by 2015. The findings from this study will be useful for a comprehensive assessment of the extent, effects and the response to VAW as provided by the National Action Plan to end gender violence (NAP).

The study's main objective is to pilot the methodology and measures of VAW experience and perpetration, gender attitudes, selected health-related behaviour and exposure to prevention campaigns among women and men in Limpopo. Specifically the project aims to:
- Quantify the prevalence of GBV in all its different forms and determine the extent of under-reporting; track and report changes;
- Quantify the economic, social and psychological costs of violence;
- Assess the effectiveness of the response by the police; courts; health; social and all related services;
- Assess the way GBV is covered by the media, how this is perceived by audiences and the extent to which the media is playing its role in helping to end or perpetuate gender-based violence;
- Assess the level of political commitment to address GBV;
- Map the underlying attitudes towards gender equality that fuel GBV;
- Assess the effectiveness of prevention campaigns from the point of view of some of the respondents to the prevalence study; and
- Provide pointers for government and civil society in Limpopo to strengthen strategies for preventing and responding to GBV.

Key research questions

The research sought to answer the following questions:
- What is the scope and extent of GBV perpetration and survivor experiences in Limpopo?
- What is the physical, social, and economic impact of GBV on society?
- What is the response of public services to GBV in Limpopo?
- What is the level of political commitment to address VAW shown by the national government?
- To what extent is the media helping to end or to perpetuate GBV in Limpopo?
- What is the impact of prevention interventions and mainstream media on VAW in Limpopo?

Key elements of the project

The study used a combination of research methodologies to test a comprehensive set of indicators and establish extensive GBV data in Limpopo. The project components comprise:
- Prevalence and attitudes household survey;
- Analysis of administrative data gathered from the criminal justice system (police, courts), health services, and government-run shelter;

[9] ibid.

- Qualitative research and collection of as first-hand accounts women's experiences and men's perpetration of GBV;
- Media monitoring; and
- Political content and discourse analysis.

Prevalence and Attitudes Household survey

The prevalence and attitudes survey is used to investigate the extent and individual effects of VAW, the underlying factors that influence GBV and to find ways to use this data to improve prevention messages and interventions.

Study design

Researchers conducted a cross-sectional household survey of women and men. The women's survey described the prevalence and patterns of women's experience of GBV, HIV risk behaviour, pregnancy history, mental health, help seeking behaviour after experiences of VAW, gender attitudes, and exposure to prevention campaigns in Limpopo. The men's survey described men's perpetration of GBV, gender attitudes, HIV risk behaviour, fathering, and exposure to prevention campaigns.

Description of the questionnaire

Researchers administered two questionnaires: one for women as survivors and the other for men as perpetrators. The women's questionnaire aimed to describe the prevalence and patterns of women's experience of GBV, HIV risk behaviour, pregnancy history, mental health, help seeking behaviour after experiences of GBV, gender attitudes, and exposure to media and prevention campaigns. The men's questionnaire aimed to describe men's perpetration of GBV, gender attitudes, HIV risk behaviour, fathering, and exposure to prevention campaigns.

The questionnaire provides information about the following areas:

- A description of gender attitudes, attitudes towards rape and relationship control among women and men;
- A description of the prevalence and patterns of childhood trauma among women and men;
- A description of the experiences of witnessing and intervening with domestic violence among women and men in all countries;
- A description of the risk/protective factors for experiencing GBV among women including socio-demographic characteristics, attitudes, partner characteristics, substance use;
- A description of the prevalence and patterns of women's experience of GBV, and associated health risks, including HIV risk factors, condom use, concurrent partners, number of sexual partners and transactional sex;
- A description of the health consequences associated with experience of GBV including self-reported STIs, HIV testing, unwanted/unplanned pregnancy, substance use, depression and post-traumatic stress disorder among women;
- A description of the prevalence and patterns of men's perpetration of GBV, associated risk factors and health risks;
- Association between gender attitudes, relationship control and perpetration of GBV among men;
- Association between men's perpetration of GBV and HIV risk factors including condom use, concurrent partners, number of sexual partners, substance use and transactional sex;
- A description of the health consequences associated with perpetrating GBV including STIs, HIV testing, fathering an unplanned pregnancy;
- A description of the awareness of campaigns against GBV and relevant legislation including the Domestic Violence Act and the Sexual Offences Act;
- An exploration of men's experience of IPV; and
- An exploration of economic abuse and its relationship to GBV.

Sampling

In order to ensure random sampling (statistical/scientific) the researchers:

- Used the list of all wards in Limpopo compiled by Statistics South Africa to randomly select 80 wards in the province. This ensured that the entire province (geographically) is represented.
- Randomly selected 80 Enumerator Areas (EA's), one in each ward. Enumerator areas are smaller than wards.

- Used printed maps for each selected EA to ascertain boundaries.
- Randomly allocated the selected EAs into male and female EAs.
- Visited selected EAs. In each selected EA, the researchers listed and randomly selected 35 households to be interviewed using the interval method. In each household, researchers selected either one male or one female using kish grids.
- Did not substitute preselected households or participants within households. Researchers visited households on at least three different days at three different times in those exceptional circumstances when the selected individual or households could not be reached at first contact.

Inclusion criteria

In order to be eligible, men and women needed to be aged 18 years or older. They also had to reside in the sampled household and be mentally competent. A person should have slept in the selected household for at least four nights a week to be considered part of it.

Strengths of the sampling method

This sampling method has several merits, including:

- It ensured that each member of the population had an equal chance of being selected;
- It ensured random selection of the sample, a characteristic which gives the possibility of carrying out further inferences such as standard errors, confidence intervals and hypothesis testing;



Participants at the VAW Baseline Study reference group meeting held in Harare in August 2012. *Photo by Trevor Davies*

- The fixed number of sample members within each EA allowed better administration of fieldwork and supervision;
- The stratification ensured representativeness of the sample over the province and thus improved precision compared to a simple random sample;
- The selection of one person per selected household reduced the risk of contamination of the responses and protection of survivors, which is considered high for such type of surveys involving sensitive questions.

Limitations of the sampling method

The survey sampling methods also presented limitations, such as:

- Some questions applied to only some respondents, for example survivors or perpetrators. The result is that only a small proportion of the sample responded to these.
- The sampling method did not allow substitution of non-respondents and so researchers made three follow-up visits in an attempt to contact a potential participant.

Fieldworker training

GL facilitated the training session in June 2012. It focused on project content, orientation, ethics training, understanding methodology, and engagement with the questionnaire. The programme also included familiarisation with the questionnaire and training on the Personal Digital Assistants (PDAs) and related activities, adherence to methodology, and communication of the deployment schedule. The training sessions included the following:

- Presentation on the domestic violence and research results generated during preceding studies;
- Ethics and gender sensitivity training;
- Extensive sessions on utilising the PDA equipment (focusing on requirements such as keeping the equipment charged and frequent synchronisation);
- Logistics and field-work implementation planning (including setting up accountability structures);
- Methodology and sampling (and adherence to this); and
- Follow-up training on PDA utilisation and methodology implementation.

Ethical considerations

The researchers invited participants to take part voluntarily. Researchers told participants that non-participation would not affect them and that they could skip any question or withdraw from the interview at any time. Participants received an information sheet about the study, which researchers read to them if necessary. After the full briefing, respondents signed a consent form before the interview. To ensure anonymity, researchers identified all questionnaires using non-consecutive study ID numbers. The study thus cannot link individuals to their questionnaires.

Due to the sensitive nature of the questions, trainers provided interviewers a session on the basic principles of trauma counselling. In addition, researchers distributed a package of support material that includes contact details for organisations that provide support and counselling to each woman interviewed.

Data collection

The research team took part in community mobilisation in the first week of July. This involved contacting the relevant elected political representatives or traditional authorities in each area to explain the purposes and content of the research. In farming areas, the team sought permission to access properties from landowners in order to interview farm workers and other residents. In some areas field managers informed local police stations of their activities. The team at all times referred to the project as a relationship study.

Researchers collected data from 6 July to 5 August 2013. Within each household, the researchers recruited only one randomly-selected eligible person (male or female depending on the EA allocation over the age of 18 years). If the sampled household member was not at home at the first visit, the researchers made three further attempts to interview the sampled participant. The researchers did not substitute if they could not interview the sampled participant. To ensure safety of respondents, the researchers did not interview men and women from the same households or EA.

Researchers administered the questionnaires using PDAs. An interviewer read each question and associated answer choices as presented on the PDA screen. The participants chose their language of preference. A skip button allowed participants to skip over any question they did not wish to answer. If participants completed the questionnaire without the assistance of the fieldworkers, the fieldworkers remained nearby so they could assist respondents or help answer any questions.

Data management and analysis

The researchers downloaded data daily from the PDAs and merged it into a complete dataset. GL conducted data analysis using Stata version 11, taking into account the survey's two stage sample design. The study design provided a self-weighted sample. All procedures took into account the two stage structure of the dataset, with the Primary Sampling Units as clusters. Researchers did not attempt to replace missing data. They used standardised formulae to calculate response, refusal, eligibility and contact rates.

Researchers summarised data as percentages (or means), with 95% confidence limits calculated using standard methods for estimating confidence intervals from complex multistage sample surveys (Taylor linearisation). Pearson's chi was used to test associations between categorical variables.

To meet objectives, this report presents descriptive statistics for the relevant variables and constructs. Data analysts compared the proportions or means for the different variables using tests of statistical significance. This report presents the results of bivariate analyses for the chi-squared tests of association between exposures and outcomes.

Characteristics of women and men participating in the prevalence and attitude study

The survey included women and men permanent residents in randomly preselected households aged 18 years and older.

Table 2.1: Sample description of participants in the prevalence and attitudes study				
Characteristic	**Women**		**Men**	
	Number	**%**	**Number**	**%**
Age				
18-29	336	38	611	61
30-44	228	27	208	21
45 +	276	35	181	18
Total	840	100	1000	100
Highest standard of education completed				
High school incomplete and lower	591	70	690	69
High school complete and higher	250	30	310	31
Total	841	100	1000	100
Race				
Black African	828	98	996	99
Coloured, Indian and other	4	1	0	0
White	8	2	4	1
Nationality				
South African	827	99	972	97
Southern African	12	1	23	3
African	0	0	3	0
Other	1	0	2	0
Total	840	100	1000	100
Worked to earn money in last 12 months				
No	706	84	667	64
Yes	134	16	333	36
Total	840	100	1000	100
Have you ever had sex				
No	54	7	74	7
Yes	759	93	901	93
Total	813	100	975	100
Ever in an intimate relationship				
No	38	5	83	8
Yes	803	95	917	92
Total	841	100	1000	100
Currently in an intimate relationship				
No	209	25	180	19
Yes	623	75	804	81
Total	832	100	1000	100
Currently living with intimate partner				
No	301	48	506	53
Yes	322	52	298	47
Total	623	100	804	100

Description of the sample

Women (38%) and men (48%) aged between 18 to 29 years formed the majority of respondents. Only 30% of both women and men had completed high school and obtained a higher qualification. The sample group comprises Black Africans. Almost all (98%) participants hailed from South Africa while 2% came from within the SADC region. The majority of women (84%) and men (64%) said they'd been unemployed in the 12 months before the survey. Ninety-seven percent of women and 92% of men had been involved in intimate relationships, while 75% women and 81% said they lived in an intimate relationship at the time of the survey. About half (52%) of women and men (47%) lived with their intimate partners.

Speaking out can set you free: the "I" Stories experience



In 2004 GL started the "I" Stories project as a part of the 16 Days of No Violence Campaign. GL staff worked with women who had experienced violence, as well as men who used to perpetrate violence, to help them write their stories. GL published these personal accounts in a booklet called the "I" Stories.

This study used the GL "I" Stories methodology to gather the experiences of violence against men and women. GL gathers women's and men's experiences of physical, sexual, psychological and economic abuse. Support organisations assist in the identification of survivors and perpetrators. During the writing workshops, facilitators share examples of published "I" Stories with participants so they can see what the final product will look like.

The stories from women survivors aim to assist in identifying the following key research questions for violence against women:

1. Are women able to identify the various forms of abuse? (Physical, sexual, psychological or economic).
2. How many women interviewed are experiencing the various forms of abuse?
3. What are the causes of violence against women?
4. What are the effects of violence against women? (Physical, psychological, economic or social).
5. How does abuse impact on ability of women to leave abusive relationships?
6. What support has been available for women experiencing abuse?

Process

TVEP project facilitators conducted the "I" Stories workshops in this Limpopo project and showed participants copies of other "I" Stories published by GL. This helped to build rapport and made participants feel comfortable because facilitators explained how their stories would be used. Those who felt uncomfortable using their real names also came to understand how to use a pseudonym. The facilitators told survivors that participation is voluntary and for research purposes. They translated the consent form from English into Venda to avoid confusion for participants who speak very little English. Participants completed the consent form and signed it, consenting to writing their story and specifying where and how it could be used and if they wanted to be photographed or interviewed in future.

Ethical considerations

The facilitators:

- Informed participants how their stories would be used and distributed;
- Sought permission from the participants to use their photographs and reveal their identities;
- Gave participants the option of using a pseudonym and not revealing their identities; and
- Required participants to sign off the final versions of their stories and approve any changes or revisions.

Administrative data

GL gathered administrative data to document the extent of GBV as recorded in public services, namely the Department of Health, SAPS, Department of Justice and Constitutional Development and Department of Social Development.

The main purpose of collecting and analysing administrative data is to complement the results of the prevalence and attitudes survey data. It is widely accepted that administrative data does not accurately provide information on the extent of VAW, more especially of intimate partner violence, mainly due to the high levels of underreporting.

In the words of gender studies expert Sylvia Walby: "It would be most unwise to treat such data as a guide to the actual level of violence in that if it were used as an indicator it might create a perverse incentive to minimise the amount of violence over time in order to suggest improvements".[10]

[10] Walby, S, op cit.

This data provides a basis for assessing the costs of GBV and - most importantly - it can provide information on the use of services by survivors and the areas in need of improvement.[11]

Description of data

Data requested from the respective institutions included:

- Numbers and nature of cases relating to the DVA, SOA; femicide and other cases reported to the police or justice related to GBV service providers for the period 2011-2012;
- Numbers, nature and status of cases relating to the DVA and SOA where charges had been brought against the alleged perpetrator for the period 2011-2012;
- Number, nature and the treatment required for health centre GBV cases for the period 2011-2012; and
- Number, nature and type of support provided by identified shelters for the period 2011-2012

This report analyses administrative data in conjunction with the results of the household survey to provide some indication on the current levels of under-reporting of GBV as well as on the adequacy of public service responses and their compliance with legislation and policies.

Media monitoring

The GL *Gender and Media Progress Study* launched in 2010 covered the nature and extent of VAW coverage in South Africa. This project analysed VAW content in the media over a period of one month. The media monitoring on GBV assessed the extent of VAW coverage, sex of sources, topics covered, depiction of survivors and sex of the journalist.

The study sought to answer the research questions outlined below.

- What topics are given the most and least coverage in the media?
- What proportion of coverage is specifically on GBV?
- What proportion of coverage mentioned GBV?
- How do media houses in each country compare with each other in their coverage of GBV?
- Of the coverage on GBV, what proportion is on prevention, the effects on victims and others, support and response?
- How do the VAW topics further break down into sub-topics?
- What is the overall breakdown of genres (news and briefs, cartoons, images and graphics, editorial opinion, features, analysis, feedback, interviews, profiles and human interest)?
- How does VAW coverage break down with regard to these genres?
- Where do the stories come from (international, regional, national, provincial, and local)?
- How does VAW coverage break down with regard to origin of stories?
- On average, how many sources does each GBV story have?
- On average, how many stories indicate the connection between GBV and HIV and AIDS?
- Overall, what is the proportion of women and men sources?
- How do individual media houses in each country compare with regard to male and female sources?
- What is the breakdown of women and men sources in the stories about, and stories that mention, GBV?
- What is the breakdown of women and men sources in the further breakdown of the GBV topic category into prevalence, effects, support and response?
- In the case of GBV sources, what proportion are persons living with HIV and AIDS, persons affected by HIV and AIDS, traditional or religious figures, experts, civil society, official and UN agencies or other?

Research tools

The media monitoring combined both quantitative and qualitative research methods. Monitors gathered quantitative data on the media's coverage of gender, HIV and AIDS and GBV. Team leaders in each country selected articles for further analysis to give more in-depth analysis to the quantitative findings.

[11] Ibid.

Quantitative research

The quantitative monitoring consisted of capturing data on the media's coverage of gender, VAW, and HIV and AIDS using a coding instrument. Researchers captured findings into a database pre-designed for this research. Monitors had to capture a specified set of data from each item.

This included information about the item itself, who generated or presented the story (presenter, anchor, reporter, and writer) and who featured in the item.

The process included:

- Daily completing standard forms for each item monitored with the assistance of a user guide prepared by GL;
- Submitting forms for checking to the team leader who generally monitored at least one medium to better understand any difficulties encountered by the monitors;
- Entering of data into a database;
- Quality control by GL;
- Delivery of the database by email to GL to be synthesised into one central database for a regional overview report, as well as country comparisons with regional averages; and
- Data analysis and generation of graphs.

Qualitative research

After the quantitative monitoring, monitors selected articles for further analysis. The qualitative analysis enhances and strengthens the quantitative findings. These case studies highlight best practices in the coverage of gender, HIV and AIDS, GBV as well as areas that need to be improved. The case studies serve to further elaborate and support many of the observations made in the quantitative analysis and answer the following questions:

- How are women and men labelled as sources in the media?
- Is there a good balance of men and women sources? Do women and men speak on the same topics, or do media reserve specific topics for men only and specific topics for women?
- Does the language promote stereotypes of men and women?
- Are physical attributes used to describe women more than men?
- How are women portrayed in the story? How are men portrayed in the story?
- Are all men and women in a society represented and given a voice in the media?
- What are the missing voices, perspectives in the story?
- What are the missing stories?

Table 2.2: Project components and tools used to gather data

Research tool/ indicators	Prevalence and attitudes survey	Administrative data	*"I" Stories*	Media monitoring
Extent	✗	✗	✗	
Effect	✗		✗	
Response	✗	✗	✗	✗
Support	✗	✗	✗	✗
Prevention	✗		✗	✗

Table 2.2 shows how these tools interrelate and how the research uses them to triangulate findings throughout the research to answer the key questions relating to extent, effect, response, support, and prevention. The flagship tool is the prevalence/attitude study, justified on the basis that statistics obtained from administrative data do not cover many forms of gender violence, and because there is underreporting for those which have been covered. However, the "I" stories, or lived experiences, give a human face to all aspects of the research. The administrative data and media monitoring provide key insights in relevant areas. Triangulation helps to verify and strengthen the findings as well as provide important information for policy-making and action planning.

CHAPTER 3
EXTENT OF VIOLENCE



Women participating at a GBV Community Dialogue in Maruleng. *Photo by Ntombi Mbadlanyana*

Key facts

Lifetime prevalence

- More than three quarters (77%) of women experienced some form of GBV at least once in their lifetime compared to 48% of men who perpetrated VAW at least once in their lifetime.
- About half of the women (51%) experienced while 44% of men perpetrated intimate partner violence.
- Thirty one percent of women experienced while 36% of men perpetrated emotional IPV in their lifetime.
- About a quarter (23%) of women experienced while 25% of men perpetrated physical IPV in their lifetime.
- Thirteen percent of women experienced and 14% of men perpetrated economic IPV in their lifetime.
- Seven percent of women experienced and 12% of men perpetrated sexual IPV in their lifetime.
- One in every five (21%) women with children reported abuse during pregnancy.
- Five percent of women reported being raped while 23% of men have raped a non-partner in their lifetime.
- Sixty-six percent of women who work reported that they had been sexually harassed in the workplace.

Past 12 months prevalence

- Thirteen percent of women experienced while 21% of men perpetrated intimate partner violence in the 12 months before the survey.
- Ten percent of women experienced and 15% of men perpetrated emotional IPV in the 12 months before the survey.
- Seven percent of women experienced and 8% of men perpetrated economic IPV in the 12 months before the survey.
- Six percent of women experienced and 10% men perpetrated physical IPV in the 12 months before the survey.
- Three percent of women experienced and 7% of men perpetrated sexual IPV in the 12 months before the survey.
- Only one in six women who had been physically abused or raped by a non-partner reported it to the police.



Everything was fine until I (Snowy) married Leonard. We met while I was working at Shayandima in 2005 and we fell in love. In 2007, I went to a FET college for three years. In my final year while writing my last exams, I became pregnant. When I told Leonard the news, we agreed that I shouldn't tell anyone, but then he told his family. They then came to pay *lobola* and took me to stay with Leonard. It was nice staying with him until I gave birth to our baby boy.

After some months, I submitted my CV and began working at a mechanical company in Shayandima. My child went to a crèche. Leonard then started to control my every move and began saying that the baby must be two years old before he can go to crèche. I disagreed with him and said that I would pay for the baby's crèche fees. I worked until December 2011 until the company closed for Christmas. At work they thanked us for the work that we had done.

Around that time, Leonard started coming home angry all of the time, shouting at everyone. Even a small thing would become a big issue. If he didn't find his clothes cleaned, then he would start to complain about it. He took my phone because he said it wasn't necessary for me to have one. When I talked, he would hurt me physically but there wouldn't be scratches, bruises or swelling to show what he had done.

On 26 April 2012 in the evening he said, "There is no watching TV unless we will be watching soccer." I went to sleep. When I was sleeping, he came to bed complaining. I made a mistake and touched him as I turned in our bed. That's when the problems started. He asked me why I had touched him when I don't do what he wants me to do.

A woman has to respect her husband. You are abusing yourself by working for small change and you are abusing the child by leaving him with my mother because you are always at work," he said to me. I responded to him. He said he would beat me because I was answering back to him while he was talking and I must keep quiet because he is my husband.
From there we started arguing and he slapped me on the face. I asked him, "Are you beating me?" and he said, "There's nothing you can do to me because I have done nothing to you." As we continued arguing, I pointed my finger at him. That's the last I remember from the incident.

I can't remember what happened next but around midnight I woke up under a mattress with wet pyjamas and water beside me. I tried to get up but my whole body was aching and when I looked around my husband wasn't in our room.

He was sleeping on a couch in the lounge. I called his brother's wife and explained to her what had happened. She told me to go to the police station because both of Leonard's parents have passed away.

The next morning I looked at myself in the mirror and saw that my eyes were red and my face was bruised and swollen. I took a bath and went to the Thohoyandou police station. They gave me a form to go to a doctor. I returned with the form completed. They told me to wait because there was a mistake. Instead of taking myself to a doctor I should have been accompanied to the trauma centre.

I was told that the police officer who would be working in the evening will help me at 6pm and at that time it was around 4pm. I waited until 6pm, officers then took me to the Tshulungouma police station to open a case there. When I got there, the police told me to forgive Leonard but I disagreed and I said, "If you don't want to help me then you can leave it."

Why did they make me wait for such a long time? By then it was 7pm. The other police officer said I should be taken to the trauma centre to sleep there so that I can cool down and think about it. They took me to Tshilidzini Hospital trauma centre.

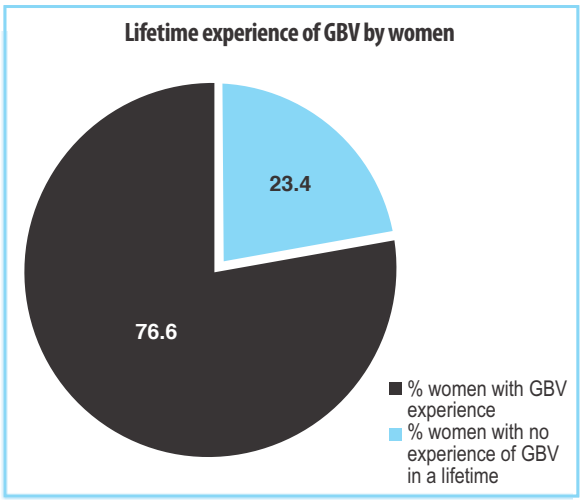
Snowy's story is an example of the different forms of violence that women experience within intimate relationships. Snowy's husband abused her emotionally, economically and physically. Snowy suffered injuries and sought help from the police and the doctor. However, she didn't get a favourable response from police as she had to wait for three hours before being referred to a trauma centre. Violence and injuries are the second leading cause of death and lost disability-adjusted life years in South Africa (Seedat et al 2009).

This chapter presents the extent of the different forms of GBV experienced by the women and perpetrated by the men within and outside intimate relationships as measured through the prevalence and attitudes survey. The prevalence and household survey did not measure some forms of GBV such as harmful cultural practice, hate crime, femicide and human trafficking. Desktop research and qualitative first-hand accounts from survivors will be used to fill gaps where statistics were not easily available.

GBV in lifetime

Researchers used two separate questionnaires in the prevalence and attitudes survey to determine lifetime experiences of GBV by women aged 18 and older and perpetration of GBV by men of similar age. Researchers first measured violence that occurred in a lifetime and then in the 12 months before the survey.

Figure 3.1: Any experience or perpetration of GBV



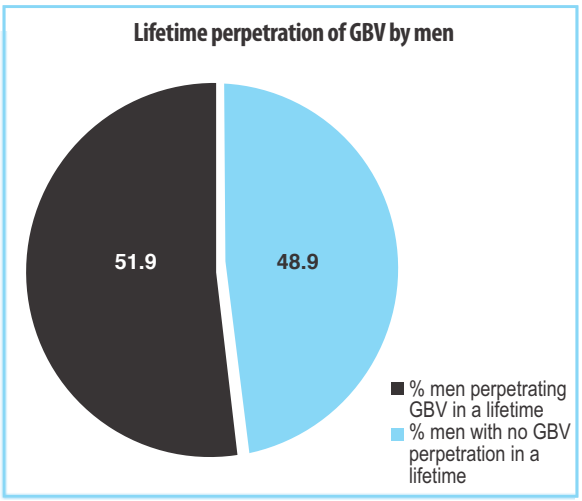


Figure 3.1 shows that more than three quarters of women interviewed (77%) reported experience of some form of GBV at least once in their lifetime while 48% of men reported ever perpetrating GBV in their lifetime. This measure of GBV includes any form of violence occurring within intimate partner relationships and sexual violence outside intimate partner violence. This finding is indicative of the high levels of lifetime experience of GBV among women in the province. It is also apparent that women in Limpopo province may be more likely to disclose experience of victimisation than men disclose perpetration. This is markedly different from disclose rates in Gauteng province, where more men disclosed perpetration than women reported VAW. This finding is notable and worthy of further interrogation.

Intimate Partner Violence

The term "intimate partner violence" describes physical, sexual or psychological harm by a current or former partner or spouse. Researchers asked

currently- or previously-partnered women a series of questions about whether they had ever experienced specific violent acts and, if so, whether this had happened in the 12 months preceding the survey. There are four main types of IPV (Saltzman et al. 2002):

Physical violence is the intentional use of physical force with the potential for causing death, disability, injury, or harm. Physical violence includes, but is not limited to, scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, slapping, punching, burning, use of a weapon, and use of restraints or one's body, size, or strength against another person.

Sexual violence includes the use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed; attempted or completed sex act involving a person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act, e.g., because of illness, disability, or the influence of alcohol or other drugs, or because of intimidation or pressure; and abusive sexual contact.

Psychological/emotional violence involves trauma to the victim caused by acts, threats of acts, or coercive tactics. Psychological/emotional abuse can include, but is not limited to, humiliating the victim, controlling what the victim can and cannot do, withholding information from the victim, deliberately doing something to make the victim feel diminished or embarrassed, isolating the victim from friends and family.[12]

Economic violence involves denying the victim access to money or other basic resources, controlling the victims' finances to prevent them from accessing resources, working or maintaining control of earnings, achieving self-sufficiency and gaining financial independence.

The most predominant form of GBV experienced by women and perpetrated by men in Limpopo province occurs within intimate partnerships. More than half (51%) of women interviewed experienced intimate partner violence, while 44% of men admitted to perpetrating it at least once in their lifetime.

Lifetime prevalence

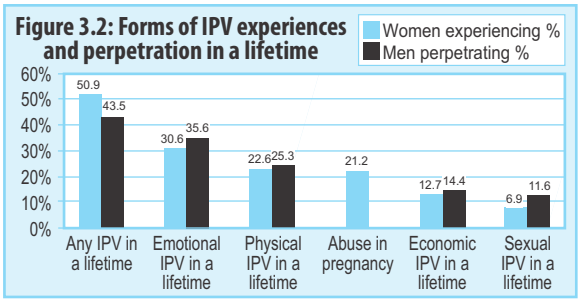


Figure 3.2 shows that the proportion of women reporting experience of all forms of IPV is greater than the proportion of men admitting perpetration. The most commonly experienced and perpetrated form of IPV is emotional followed by physical, then abuse during pregnancy, economic and lastly sexual abuse. Thirty-one percent of women experienced and 36% of men perpetrated emotional IPV in their lifetime. About a quarter of women (23%) and men (25%) reported physical IPV experience and perpetration respectively. More than a tenth of women (13%) and men (14%) reported economic IPV experience and perpetration respectively. Seven percent of women experienced and 12% of men perpetrated sexual IPV. About one in every five women (21%) who had ever been pregnant reported abuse during at least one of their pregnancies.

Table 3.1: Experience of IPV and non-partner rape from "I" Stories

	Physical IPV	Emotional IPV	Economic IPV	Sexual IPV	Non-partner rape
Experience	7	7	5	4	9

Sixteen female survivors of violence shared their stories. Nine (56%) of these women experienced non-partner rape while seven (44%) experienced intimate partner violence. All of the seven women who experienced IPV reported multiple forms of abuse including physical, emotional, economical and sexual. The most reported IPV is emotional and physical.

[12] Saltzman et al, 2002.

Emotional IPV

Researchers assessed emotional IPV using six questions that asked about a series of different acts that control, frighten, intimidate or undermine women's self-esteem. The survey asked women participants if a male partner had ever insulted them or made them feel bad; belittled or humiliated them in front of other people; threatened to hurt them; stopped them from seeing friends; done things to scare or intimidate them; or boasted about or brought home girlfriends. The survey asked men if they had done any of these things to a female partner.

The following excerpt is an example of the many insults that Promise Mudau received from her husband. *"One day he came back in the evening and found me sleeping. He said to me, house is dirty." "I want food." So I woke up and made the pap. Then he said I shouldn't bother cooking for him anymore, he can cook for himself. I said that was fine. He didn't eat the food. He saw a Purity bottle on the floor and said, "Nowadays you are lazy and the house is dirty."*

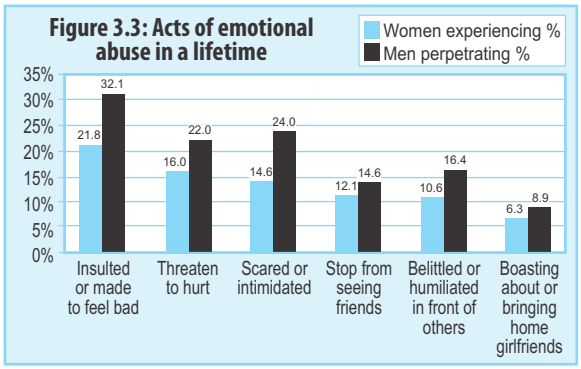


Figure 3.3 illustrates that emotional violence, such as insults, is the most common act of IPV. More than a fifth (22%) of the women said they had been insulted or made to feel bad by their partner. Thirty-two percent of men disclosed doing this. Sixteen percent of women had been threatened, 15% of women reported feeling scared or intimidated, 12% had been stopped from seeing friends, 11% had been belittled, and 6% said their intimate partners boasted about or brought home girlfriends.

About 24% of the men surveyed had intimidated a partner, 16% belittled a woman, 15% stopped their partners from seeing friends and 22% threatened to hurt a partner. About 9% of men boasted about, or brought home, girlfriends. Emotional abuse tends to have enduring negative effects on its victims and sometimes even has greater impact than physical abuse on women's psychological functioning, particularly within the areas of depression and posttraumatic stress disorder (PTSD).[13]

Acts of emotional IPV from the "I" Stories

A significant number of women had been cheated on by a partner. Some of the men even bragged about it to their partner. Women commonly report that a partner has called them names such as lazy, dirty, liar, etc. Other forms of emotional abuse included being humiliated in front of people and ill treatment of children by the partner, an extreme example of the latter is a case in which a father raped his own daughter.

Promise* also had to endure physical abuse from her husband. *"On that day, Ndivhuwo* beat me with a piece of iron and my body was swollen and blue. I went to my grandmother's home and left our son with Ndivhuwo* because I couldn't run away carrying him. My grandmother told me not to get Ndivhuwo* arrested because he is the father of my child."*

Physical IPV

Researchers assessed physical IPV by asking five questions about whether women had been slapped, had something thrown at them, had been pushed or shoved, kicked, hit, dragged, choked, beaten, burnt or threatened with a weapon. Similarly, the survey asked men if they had done any of these acts to their intimate partners.

[13] Pico-Alfonso, 2005.Psychological intimate partner violence: the major predictor of posttraumatic stress disorder in abused women. Neuroscience and Biobehavioral Reviews 29 (2005) 181-193.

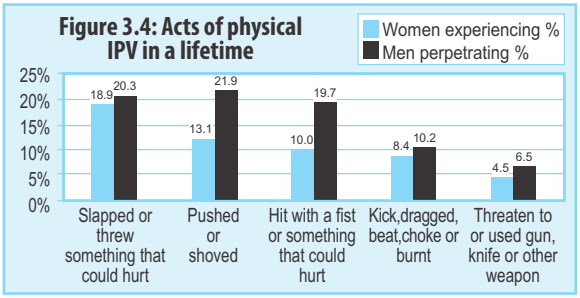


Figure 3.4 illustrates that a greater proportion of men reported various acts of physical IPV. The most common act reported by women is being slapped or having something thrown at them. About a fifth of women (19%) and 20% of men reported this. Thirteen percent of women had been pushed or shoved; 10% had been hit with a fist or dangerous object; 8% had been kicked, dragged, chocked or burnt and 5% said they had been threatened with a gun or other weapon.

Twenty two percent of men pushed or shoved; 20% hit a partner with a fist or dangerous object, 10% kicked, dragged, chocked or burnt a partner and 7% threatened a partner with a gun or other weapon.

Table 3.2: Frequency of physical IPV

Criteria	Women experiences (%)	Men perpetration (%)
Never	77.4	74.8
Once	11.9	12.0
More than once	10.7	13.2

Table 3.2 shows that a larger number of men who perpetrated physical IPV did it on more than one occasion. About one in every seven (13%) men participating in the survey perpetrated physical IPV more than once in their lifetime. A lesser proportion of men (12%) perpetrated physical IPV once in their lifetime.

In contrast, more women who experienced physical IPV reported it as a one-time incident. About one in eight of women (12%) participating in the survey experienced physical violence once in their lifetime while 11% experienced this more than once. These findings indicate the often recurrent nature of physical IPV within relationships.

Extent of reporting physical IPV in lifetime

The survey asked women who reported experience of physical IPV in their lifetime whether they reported the incidents to the police or a health facility.

Table 3.3: Extent of reporting physical IPV in a lifetime

Criteria	%
Proportion of women who had been physically abused or injured in an intimate partnership in their lifetime and who sought medical attention	2.3
Proportion of women who had been physically abused in an intimate partnership in their lifetime and reported it to police	2.7

Table 3.3 shows that almost similar proportions of women who experience physical IPV report to the police and health services. About three percent of women who had been physically abused by intimate partners reported it to the police while 2% sought medical attention as a result of the injuries sustained.

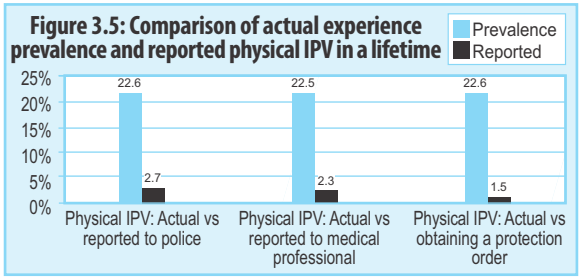


Figure 3.5 shows that there is widespread under-reporting of physical IPV both to police and to health care facilities. Only one in eight women who had been physically abused by intimate partners reported it to the police. A lower proportion of women - one in ten - sought medical attention after physical abuse. One in fifteen women obtained a protection order against a physically abusive partner.

Acts of physical violence from the "I" Stories

Beating using fists or objects such as broomsticks or stones is the most common act of physical violence by intimate partners. Several women also reported

having been threatened with a knife. Many women also reported being punched or slapped. Some women reported that their partner had destroyed important documents.

Sexual IPV

Sexual violence[14] is non-consensual completed or attempted contact between the penis and the vulva or the penis and the anus involving penetration, however slight; non-consensual contact between the mouth and the penis, vulva, or anus; non-consensual penetration of the anal or genital opening of another person by a hand, finger, or other object; non-consensual intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks.14 All the above acts qualify if they have been committed against someone who is unable to consent or refuse. Sexual violence is therefore an umbrella term for either completed or attempted sex acts without the survivor's consent, or involving a survivor who is unable to consent or refuse.

Keketso said, *"He took out his knife and started to undress me. Then he started raping me. He raped me for two to three hours between 5 and 7pm. After that he told me that he wanted to be with me for the rest of his life and that the next day he wanted to go with me to Pretoria because if he lets me go, I would get him arrested."*

The study assessed sexual IPV experienced by women using three questions. These covered: if their current or previous husband or boyfriend had ever physically forced them to have sex when they did not want to; whether they had had sex with him because they had been afraid of what he might do and whether they had been forced to do something sexual that they found degrading or humiliating.

Table 3.4 shows that the majority of women who experienced sexual IPV said it had occurred on more than one occasion. Four percent of women participating in the survey experienced sexual IPV more than once in their lifetime while three percent experienced this only once. Similarly, the majority of men perpetrating sexual IPV have done so more than once. Seven percent of men participating in the survey perpetrated sexual IPV more than once in their lifetime while five percent did this once.

Table 3.4: Frequency of sexual IPV

Criteria	Women experiences (%)	Men perpetration (%)
Never	93.0	88.4
Once	2.9	5.1
More than once	3.9	6.6

Economic IPV

Economic or financial abuse takes many forms, including controlling the finances, withholding money or credit cards, giving a partner an allowance, making a partner account for every penny spent, stealing or taking money from a partner, exploiting a partner's assets for personal gain, withholding basic necessities (food, clothes, medications, shelter), preventing a partner from working or choosing a career, or sabotaging a partner's job by making them miss work.[15]

Tivhu said, *"My husband didn't allow me to go to school because he said if I become educated then I would run away from him, but my parents insisted that I should go back to school. I continued going to school and passed my grade 12 at the end of the year. He didn't even allow me to go to work because he said, "A woman who works becomes a prostitute".*

This study looks at several types of economic IPV: withholding money for household use, prohibiting a partner from earning an income, taking a partner's earnings or forcing a partner and children to leave the house.

[14] Violence and associated terms by Basil and Saltzman (2002).
[15] http://www.4woman.gov/violence/types/emotional-cfm

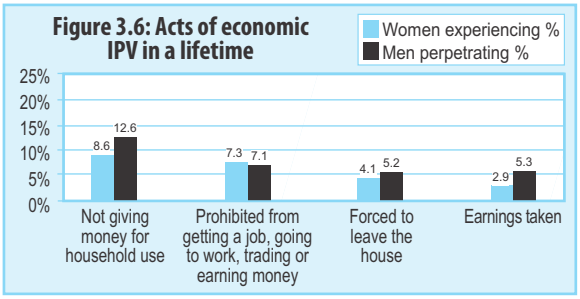


Figure 3.6 shows that women most commonly experience having money withheld for the household while men reported withholding money. Nine percent of women reported that a partner refused to contribute to the family welfare and give her money for household use when in a position that he could provide. One in eight men (13%) admitted to doing this.

The second most common act of economic IPV experienced by women and perpetrated by men involves women being prohibited from pursuing income generating activities. Seven percent of women experienced this while 7% of men said they had prohibited partners from pursuing paid work or trading. Four percent of women had been evicted from their home and 3% had been forced to hand over their earnings.

Acts of economic IPV from the "I" Stories

"I" Stories participants most commonly write about being prohibited to work or go to school. If women insisted on working, their male partners called them prostitutes. Another form of economic IPV occurs when a male partner refuses to provide for his family. In some instances the partner would look after his parents, siblings or girlfriend at the expense of his wife and children. Other men tended to take money from their partner without her consent. Women also commonly reported that they had been chased out of the home by their partner.

Abuse in pregnancy

This study explored the prevalence of IPV among pregnant women. Men often blame their abusive behaviour on a pregnancy. Abuse in pregnancy may also be a continuation of a longstanding abusive relationship that gets worse after a woman becomes pregnant. It may also commence because of various reasons, such as unintended pregnancy or suspicion of birth control sabotage. The research asked women if they experienced acts of abuse during a pregnancy.

"In 2000 when I was nine months pregnant with my last child my husband was chasing after me. I fell and broke my leg. I gave birth before my leg could heal. Soon after the birth I returned to the hospital to be sterilised."

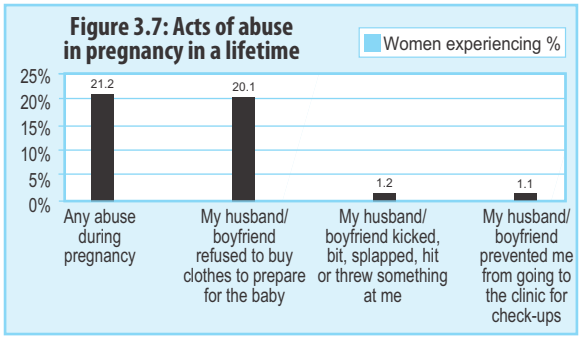


Figure 3.7 shows that a fifth of all women (21%) reported abuse during pregnancy. The survey found economic abuse to be the most predominant form. This involved male partners refusing to contribute to preparations for the baby. A fifth (20%) of women reported this. One percent of women said they had been physically abused during pregnancy or prevented from seeking antenatal care.

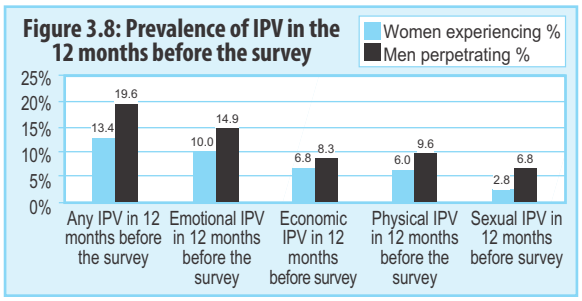


Figure 3.8 shows that one in seven (13%) women reported IPV experience while a fifth (20%) of men reported IPV perpetration in the 12 months before

the survey. Similar to the lifetime prevalence trends, the most common form is emotional IPV. A tenth of women (10%) reported experiencing it, while 15% of men reported perpetrating emotional IPV. However, economic IPV is also common, followed by physical IPV (6%) and sexual IPV (3%). A greater proportion of men reported perpetration of all forms of IPV.

These findings indicate significant current prevalence of IPV in Limpopo province, highlighting a need for strategic action. It is necessary to develop plans that aim to reduce the different forms of violence, particularly the predominance of emotional IPV. It is also important to tackle sexual violence by intimate partners alongside combating sexual violence in the context of non-partner experiences.

Table 3.5: Extent of reporting physical IPV in past 12 months

Criteria	%
Proportion of women who experienced physical IPV in 12 months before the survey	6.0
Proportion of women who experienced physical IPV in 12 months before the survey and reported incident to police	3.8
Proportion of women, who experienced physical IPV in 12 months before the survey and sought medical attention	1.6

Table 3.5 shows significant underreporting of physical IPV. However, more women reported physical IPV in the 12 months before the survey than that which happened over their lifetimes, suggesting a general increase in women's reporting of physical IPV. Two in every three women (4%) who had been physically abused by their partner reported it to police. One in every four physically abused women sought medical attention after injuries.

Non-partner rape

The study assessed this by asking three questions: Had a man (not a husband or boyfriend) forced or persuaded women to have sex against their will? Had the woman been forced to have sex with a man when too intoxicated to stop him? Had the woman been forced to have sex with more than one man at the same time? The latter is referred to as gang rape. The survey asked men whether they had ever forced women into any of these acts.

Lifetime prevalence

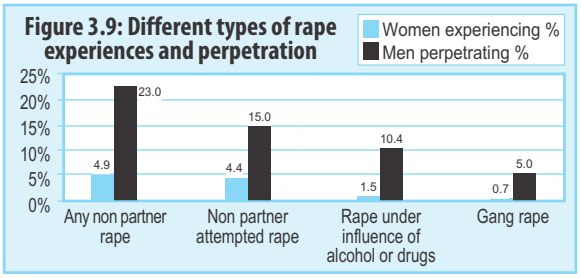
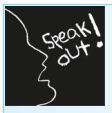


Figure 3.9 shows that a greater proportion of men reported non-partner rape perpetration compared to the proportion of women reporting that they had been raped. Fifteen percent of men attempted to rape, 10% raped a drunken or drugged woman without her consent and 5% participated in a gang rape. The story outlined below is a survivor's account of non-partner rape in South Africa.



My story began on a Wednesday, 8 August 2012. My friend Shonie and I (Naledi) were waiting for a taxi coming from a church service, around 8pm. When we reached the bus stop a man approached us. The man greeted us and joined us in trying to get a lift.

As we were waiting one car stopped a short distance away from us. We began to run towards it. When the driver realised that it was not only the two of us, he drove off. This happened with three other cars.

We decided to move past the man so that when we stopped a car he would be behind us. As we approached where he was standing he grabbed my hair. I was wearing a weave at the time. I was scared and started screaming, he hit me with a fist on my nose and I lost my balance and I tripped and fell alongside the road. He didn't let go of my hair, he continued to pull me.

My friend managed to run for her life. She was nowhere to be found. The perpetrator took a knife out of his back trouser pocket and ordered me to get up and move from the roadside into the nearby bushes. I was crying and in shock. I asked him what he wanted. He didn't answer; he just punched me in my face again.

I took my phone out and offered it to him. I said, "If it's the phone and money you want then you can have them and leave, but please spare my life."

He took the phone and put it in his back pocket together with the R50 note I had for transport. He ordered me to lie down which I didn't want to do. When I refused, he punched me on the nose again. I saw blood coming out of my nose. He started kicking me everywhere and I lost my balance and fell to the ground.

He put back his knife and sat on my legs, he put his hand on my blouse and tried to remove my bra, then he was touching my breast. I screamed and said "Oh my Jesus," then he suddenly stopped touching me and hit me on the head with a nearby brick. He took off my trousers and panties, and touched my private parts with his hands.

He unzipped his trousers, and then ordered me to open my legs. I still refused, and he hit me again with a brick on my left eye. He started raping me. While he was busy doing that I managed to take my phone out of his back pocket without him realising. As I did that, the knife fell out of his pocket on the ground. I managed to move my body so I was lying on his knife and he couldn't see it. Then I immediately grabbed him by his neck with both of my hands.

He screamed and hit me once again with a fist but I didn't let go. He got up and tried to search for his knife and I also got up and screamed. He ran away and I also managed to run to the nearest house for help. They called a satellite police station and it didn't even take the police 20 minutes to come. They took me to the hospital because I was bleeding from my nose and I had a cut on my leg.

Table 3.6: Frequency of non-partner rape

Criteria	Women experiences (%)	Men perpetration (%)
Never	95.0	77.3
Once	2.8	13.2
More than once	2.1	9.5

Table 3.6 shows that about 3% of women experienced non-partner rape once. A higher proportion of men had raped (13%) women on one occasion. Two percent of women had been raped, while 10% of men raped, more than once.

Under-reporting of rape

Researchers asked women who had been raped by non-partners further questions about whether they had reported it to police or if they had sought medical help.

Table 3.7: Extent of reporting rape and accessing services in a lifetime

Criteria	%
Proportion of all women who were raped in lifetime	4.9
Proportion of all women who had been raped and reported incident to police in lifetime	0.8
Proportion of all women who had been raped and sought medical attention in lifetime	1.0
Proportion of all women who had been raped and accessed PEP in lifetime	0.6
Proportion of all women who had been raped and sought professional counselling in lifetime	0.6

Table 3.7 shows the significant underreporting of non-partner rape by women victims, both to police and to health care facilities. Only one in every six women who had been raped by non-partners reported it to police. A fifth of rape survivors accessed PEP or sought professional counselling. One in every five women who had been raped sought medical attention. This finding appears low but it is actually considerably higher than what is found in the annual crime statistics reports. The SAPS Annual Crime report found that 0.17% of women reported a sexual offence in 2011.[16]

[16] Total number of sexual offences 2011/2012 (31 299)/total female adult midyear population 2011 (18 229 333).

Sexual harassment

Sexual harassment means any unwelcome sexual advance, request for sexual favour, verbal or physical conduct or gesture of a sexual nature, or any other behaviour of a sexual nature that might reasonably be expected or be perceived to cause offence or humiliation to another. Such sexual advances or requests arise because of unequal power relations (SADC Protocol on Gender and Development). Researchers asked women if they had experienced sexual harassment in the workplace, schools, whilst using public transport, or when seeking help from traditional or religious leaders.

Table 3.8: Sexual harassment lifetime prevalence

Sexual harassment in a lifetime	Limpopo %
Any sexual harassment in lifetime	54.8
At workplace	65.7
At school	57.3
Touched sexually by a conductor/taxi driver/taxi rank marshal	0.9
A traditional healer said I should have sex with him	1.2

About two thirds (66%) of women in Limpopo reported being sexually harassed in the workplace. In many cases men either hinted or threatened that a woman would lose her job if she did not have sex with him. It is also common for women to be asked for sex in order to get a job. The high prevalence of sexual harassment in the workplace in Limpopo province warrants further research.

Sexual harassment in school in this study means disclosure that a teacher or principal or lecturer had hinted or threatened that a student could fail exams, get bad marks, or that their schooling would be adversely affected, if they failed to return a sexual favour. Again, the prevalence of this is remarkably high in Limpopo province. More than half (57%) of women in Limpopo who had attended school said they had been sexually harassed at school. Based on the high prevalence of this type of sexual harassment in Limpopo province compared to elsewhere, it will be important for institutions or organisations specialising in GBV prevention programmes to develop materials and interventions aimed at curbing this widespread problem.



Capricorn Municipality at the Take Back the Night march , Seshego, Limpopo. *Photo by Nomthi Mankazana*

Conclusion

This chapter has explored the extent of GBV in its various manifestations in the Limpopo province. GBV can either be between intimate partners or non-intimate partners. The study juxtaposed perpetration rates against experience rates to give a clear picture on the variances. Emotional violence featured as the most common form of abuse reported by women and disclosed by men, followed by physical then economic and lastly sexual abuse. Ironically, despite this area being the most commonly experienced form of violence, police statistics do not capture emotional violence. GBV survivors have limited access to psychological services. A fifth (21%) of all women reported abuse during pregnancy.

A greater proportion of men compared to women reported non-partner rape perpetration as well as other acts of physical IPV. This section also noted the significant underreporting of both physical IPV and non-partner rape to the police and health care facilities in the 12 month before the survey. Limpopo recorded exceptionally high prevalence rates of sexual harassment at both the workplace and in school.

In light of these findings there is a need to develop strategies aimed at reducing the different forms of violence, particularly emotional IPV, predominant in this study. It is also necessary to tackle sexual violence perpetrated by intimate partners, noting that sexual violence is often addressed only in the context of non-partner experiences.

CHAPTER 4
PATTERNS AND DRIVERS



Different socio-demographic and background factors influence the prevalence of GBV. *Photo courtesy of GCIS - Government Communications and Information Systems*

Key facts

- Women of all ages are equally vulnerable to IPV experience.
- Women and men of different educational status are equally vulnerable to VAW experience or perpetration respectively.
- Research found women are vulnerable to IPV experience regardless of whether they had worked in a job or stayed home.
- There is a link between alcohol use and IPV experience among women in the 12 months before the survey.
- Alcohol and drug use is associated with IPV perpetration among men in the 12 months before the survey.
- More than three quarters of women experienced some form of child abuse in the form of sexual, physical abuse or neglect.
- A greater proportion of men who had been physically, sexually abused or neglected as children disclosed that they perpetrated IPV at least once in their lifetime compared to men who had no experiences of child abuse.
- Two in every five (41%) men who had been sexually abused as children reported that they had raped, compared to 18% of men who did not experience child sexual abuse.



I (Promise) am an unemployed woman. In 2009 I started dating Ndivhuwo, but he was also dating another woman. I became pregnant and gave birth to a baby boy. His parents were not interested in discussing marriage (lobola) with my relatives. When he came home drunk he would wake me up and force me to prepare food for him. He would also force me to eat with him even though I had already eaten. His mother would say, "A woman perseveres through everything even if she is abused in front of other people."

I didn't know what to do because I loved him. Even when he talks, I would just agree to do anything he told me to do. He told his sisters and mother that they mustn't do any house work; instead I must do all the work. If he found me sitting doing nothing he would start shouting at me in order to please them.

The day he found out that his other girlfriend was also dating his friend, he came home and beat me with a piece of iron saying that he no longer loved me. He said he had found another woman at the shebeen who is more beautiful than me. The other day, another girlfriend of his came to the house and told me to leave her husband. Then Ndivhuwo beat me with a piece of iron until I decided to run away. My body was swollen and blue. I went to my grandmother's home that same night and left our son with Ndivhuwo because I couldn't run away carrying him. My grandmother told me not to get Ndivhuwo arrested because he is the father of my child.

In 2012 I became pregnant while he was not working. He was abusing me all the time. When his mother came to visit us she said I should give her my children and go back home because the children belonged to her son. On 2 August 2012 he came back in the evening and found me sleeping and he said to me, "I want food." So I woke up and gave him food. Then he said to me I shouldn't bother cooking for him anymore, he can cook for himself. I said that was fine. So he didn't eat the food. He saw a purity bottle on the floor and started saying to me, "Nowadays you are lazy and the house is dirty."

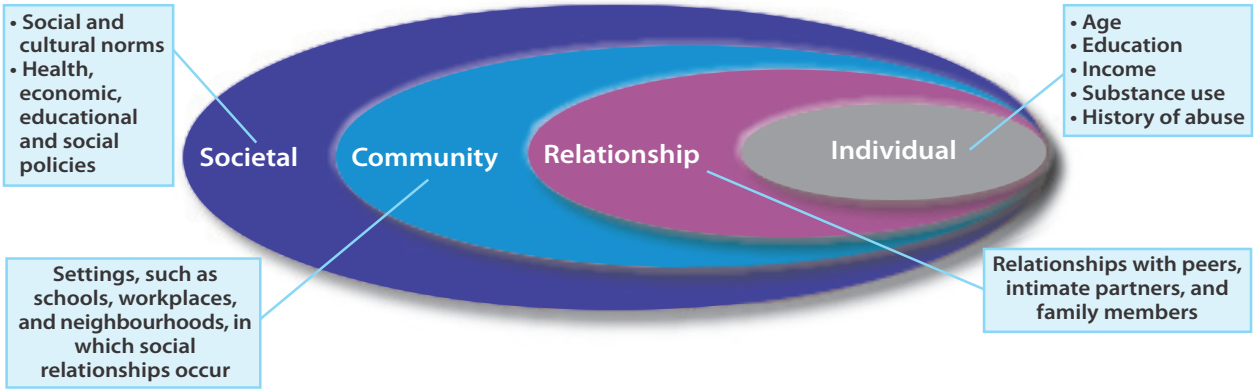
He took the pap and threw it at me and it landed on my back. He said he wanted to sleep with me forcefully because I am disrespecting him. I then ran to an outside toilet. While sitting there I heard my baby crying in the house and when I tried to get inside I found that my husband had locked the door and would not open the door. I sat there at the door until it was around 1am. I knocked again and he opened the door holding a broomstick. He started chasing me. I decided to run to the police station. I was not wearing clothes, I was only wearing panties. The police gave me clothes to cover myself. They took me home and when we got there I found him sleeping with my children. The police asked him to open the door and when he did I took my children and went to the trauma centre at Tshilidzini Hospital. I opened a case, but it never progressed because the accused was the father of my children. Back at home Ndivhuwo was remorseful and said, "It was alcohol not me." He said he was sorry.

Now we have our own separate lives, even though we are still living together, but there is no love anymore. He doesn't want me to succeed in life. He doesn't want me to visit places with other women where we would be talking about girly things. I said, "Let's separate," he said he would kill me and be with another woman that he loves. My children will suffer without their father. He said he wants me to stay because he doesn't want his children to suffer. He wants to build a good future for them and I should forgive him. I also could not leave because I am an orphan and don't have anyone to support me. I really regret that I bore his children because he abuses me. With everything that has happened I am scared to continue living with him.

Promise's husband physically, sexually and emotionally abuses her, citing alcohol as an excuse. As an orphan with nowhere else to go she is left with no option other than to endure the abuse for the sake of her children. External influence from family members as well as extra-marital affairs can both be seen as drivers of violence. Promise expresses her wish to leave the relationship as well as the fears that hold her down.

This chapter explores individual, family/relationship, community and societal factors that impact on adult behaviours as shown by the Ecological Model Framework. The chapter draws on the prevalence and attitude survey, as well as the political content analysis, to draw out the causes or drivers of gender violence in Limpopo - both immediate and longer term.

Figure 4.1: The ecological model of factors associated with VAW



The ecological model in Figure 4.1 attempts to explain why some violence occurs, why some men can be more violent than others and why some women consistently find themselves in abusive relationships. Understanding the reasons for, and the factors associated with, experience or perpetration of gender violence is a precursor in the design of GBV prevention programmes. The study investigated the association between the experience and perpetration of violence with individual, family, community and societal characteristics of participants. The study also explored social norms around gender relations.

Individual level factors

Individual level influences comprise personal factors that increase the likelihood of becoming a victim or perpetrator. Examples include socio-demographic factors, attitudes and beliefs that support IPV, isolation and a family history of violence.

Socio-demographic factors

Socio-demographic characteristics explored include age, education level and employment status.

Table 4.1: Disaggregation of experience and perpetration of IPV by socio- demographic factors

Factors	Ever IPV				Past 12 months IPV			
	% women survivors	Chi(p)	% men perpetrating	Chi(p)	% women survivors	Chi(p)	% men perpetrating	Chi(p)
Age								
18-29	51.7	0.3	44.3	0.00	33.4	0.7	16.2	0.02
30-44	55.1		45.2		26.4		14.6	
45+	47.0		40.5		11.6		9.7	
Level of education								
O level incomplete and lower	50.8	0.9	44.1	0.7	25.3	0.8	13.0	0.1
O level complete and over	51.3		42.6		30.7		14.6	
Worked in past 12 months								
No	50.2	0.4	42.6	0.4	23.2	0.6	12.8	0.6
Yes	54.8		45.2		34.3		16.9	

Age

Table 4.1 shows that there is no statistically significant difference in the proportion of lifetime IPV survivors (p=0.3) by age. There is also no significant difference in proportion of survivors by age in the past 12 months (p=0.1). By implication, women of all ages are equally vulnerable to IPV experience.

There is no statistically significant difference in IPV perpetration among men in lifetime by age. However, there is a significant reduction in the proportion of perpetrators by age for the 12 months before the survey. Men in the 18-29 age category comprise the highest proportions of perpetrators with the lowest in the 45+ age group. This illustrates a need to engage and target younger men in GBV prevention programmes.

Education level

Table 4.1 shows a person's level of education doesn't seem to be a factor for IPV survivors or perpetrators of IPV in lifetime or the past 12 months. This means women and men of different educational status remain equally vulnerable to GBV experience or perpetration.

Employment status

There is no significant difference in proportion of survivors and perpetrators between employment status in the 12 months before the survey and in lifetime.

Table 4.2: Disaggregation of experience and perpetration of rape by socio- demographic factors

Factors	Ever non-partner rape				Past 12 months non-partner rape			
	% women survivors	Chi(p)	% men perpetrating	Chi(p)	% women survivors	Chi(p)	% men perpetrating	Chi(p)
Age								
18-29	5.9	0.03	21.6	0.02	0.6	0.2	5.8	0.08
30-44	7.0		29.6		0.2		1.9	
45+	2.1		17.7		0.3		1.6	
Level of education								
O level incomplete and lower	4.4	0.3	21.1	0.07	0.8	0.9	3.4	0.5
O level complete and over	6.1		26.4		0.7		4.2	
Worked in past 12 months								
No	4.3	0.06	22.4	0.08	0.7	0.3	4.8	0.005
Yes	7.7		23.2		1.2		1.7	

Age

Figure 4.2 shows that there is a significant difference in the proportion of rape survivors by age. A significantly higher proportion of women aged 30-44 reported rape in their lifetime. However, there is no significant difference in the proportion of rape survivors victimised in the 12 months before the survey. A significantly higher proportion of men aged 30-44 reported rape perpetration in their lifetime.

Table 4.2 shows that there is no significant difference in the proportion of rape survivors and non-survivors by educational status (p>0.05). More unemployed men reported perpetrating rape than those with jobs.

Alcohol and substance abuse

This study looked at the links between alcohol and substance abuse and VAW. Questions relating to alcohol and drugs included whether the respondent had used alcohol in the 12 months prior to the survey and if so, how often. The survey asked participants whether their current or most recent partner consumed alcohol and how often. Questions on substance use included whether the respondent or their partner use drugs and how often.

Table 4.3: Alcohol and drug consumption patterns by women and men		
	% Women	% Men
Have you consumed alcohol in the past 12 months		
No	88.6	43.3
Yes	11.4	57.7
How often do you take a drink containing alcohol		
Monthly or less	52.1	39.5
2-4 times a month	30.2	24.9
2-4 times a week	11.5	22
4+ times a week	6.3	13.6
More than five drinks on one occasion		
Never	34.0	4.9
Less than monthly	37.1	37.3
Monthly	19.6	27.8
Weekly	8.2	25.0
Daily or almost daily	1.0	5.3
Current partner alcohol frequency		
Every day/nearly every day	4.6	0.4
Only at weekends	20.5	5.7
A few times in a month	11.7	5.9
Less than once a month	9.0	5.9
Never drank	51.2	81.8
Stopped drinking	3.0	0.3
Used dagga in the last 12 months		
No	99.6	81.5
Yes	0.4	18.5
Current or most recent partner drug use		
No	96.3	97.7
Yes	3.7	2.3

Table 4.3 shows that 12% of women and 58% of men consumed alcohol in the 12 months prior to the survey. However, the majority of women (52%) said they are occasional drinkers. Less than a tenth of women (9%) who consumed alcohol took more than five drinks per occasion on a weekly or daily basis. About a fifth (18%) said they drank regularly, at least twice a week. More than half (54%) of the women reported being in intimate relationships with men who drank alcohol, while 4% of women had partners who use drugs.

Researchers found that 88% of men consume alcohol at least twice a week. More than a quarter of men (28%) binge drink more than five drinks on a daily basis.

Table 4.4: Partner alcohol or substance use and experience of IPV in past 12 months		
	% men perpetrators in past 12 months	Chi (p)
Drank alcohol	23.9	0.02
Did not drink alcohol	17.0	
Used drugs	33.3	0.002
Did not use drugs	18.2	

Table 4.5 shows that drinking alcohol and drug use is associated with IPV perpetration among men in the 12 months before the survey. About a quarter of men who drank alcohol in the 12 months before the survey also perpetrated IPV in the same period. In contrast, 17% of men who did not drink alcohol also perpetrated IPV in a similar period. A third of drug users (33%) compared to 18.2% of non-drug users perpetrated IPV in the 12 months before the survey.

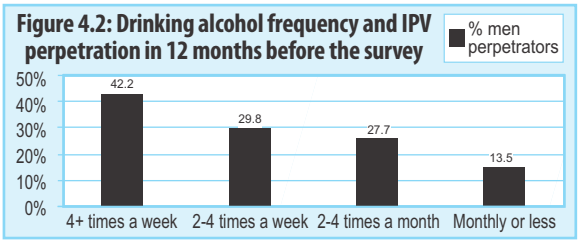


Figure 4.2 illustrates that men appear more likely to perpetrate IPV if they frequency drink alcohol. Men who drank alcohol four or more times a week are most likely to report IPV perpetration in the 12 months before the survey. Forty-two percent of men who drank alcohol four or more times a week perpetrated IPV, while 14% of men who drank alcohol once a month or less perpetrated IPV in a similar period.

Child abuse

The study asked participants about experiences of childhood neglect and abuse. It ascertained child abuse through a series of questions about forced sex, unwanted sexual touching, being severely beaten leaving marks and neglect by family, teachers or other community members.

Definition of forms of child abuse

Child physical abuse

Child physical abuse is defined as ever experiencing an incident such as being beaten with a whip and left with a bruise or mark. This could have occurred at home, school or in the community.

Tivhu shared the tragic story of her daughter, who was raped by her own father. "One day when I came back home I found my eldest daughter crying. She told me that her father has asked her if it was true that she had been raped and if he could check, then he had also raped her. When I asked him about it he said I could go and report him. So I went to open a case but it wasn't taken any further."

Child neglect

Child neglect in this study includes not being given enough food, parents being too intoxicated to care for their children, or children spending time outside the home without adults being aware of their whereabouts.

Child sexual abuse

To ascertain experiences of child sexual abuse, the survey asked participants whether they had ever been touched sexually or forced to touch someone, whether they had sex with someone of the opposite sex who was more than five years older, or whether they had been forced to have sex before they turned 18 years old. Four percent of women and five percent of men experienced child sexual abuse.

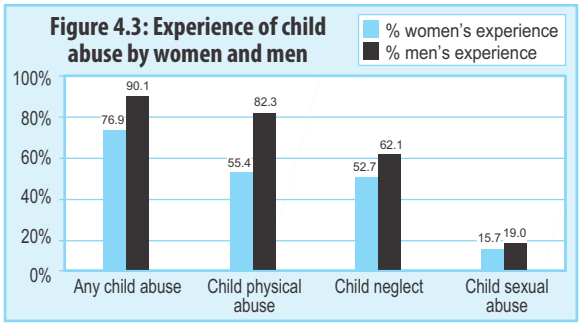


Figure 4.3 shows a high prevalence of child abuse experiences amongst women and men in Limpopo province. More than three quarters of women and nine in every ten men said they experienced some form of child abuse. Men and women most commonly reported physical abuse. More than half of the women (55%) and 82% of men experienced some form of child physical abuse in their lifetime. Meanwhile, 53% of women and 62% of men said they had been neglected as children and one in every six (16%) women and 19% of men had been sexually abused. While both women and men reported experiences of child abuse, greater numbers of men appear to have experienced a difficult childhood.

Child abuse as a risk factor for IPV perpetration
Experiences of abuse throughout life can influence family violence, both for victims and perpetrators. This study explored the link between child abuse experience by men and perpetration of IPV in lifetime using chi square tests of association.

Figure 4.4: Childhood trauma factors associated with perpetration of IPV

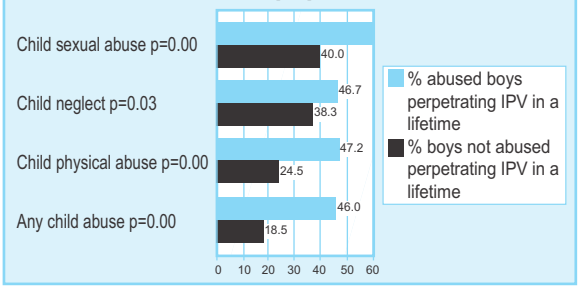


Figure 4.4 shows that a greater proportion of men who suffered abuse as children disclosed that they perpetrated IPV at least once in their lifetime when compared to men who had no experience of child abuse. This finding is consistent with research conducted elsewhere in South Africa that found a high burden of depression among youths and school going children associated with childhood trauma (Jewkes et al, 2006; Hamber & Lewis, 1997). Further research is necessary to explore whether depression acts as a mediator to the perpetration of interpersonal violence, in particular IPV.

These findings illustrate the need for child rehabilitation programmes for abused children coupled with campaigns advocating for reduction of child abuse. Prevention of child abuse may ultimately contribute to prevention of IPV perpetration. It also underscores the need to engage boys from a younger age.

Child sexual violence as a risk factor for rape perpetration

Figure 4.5: Childhood trauma factors and perpetration of non-partner rape

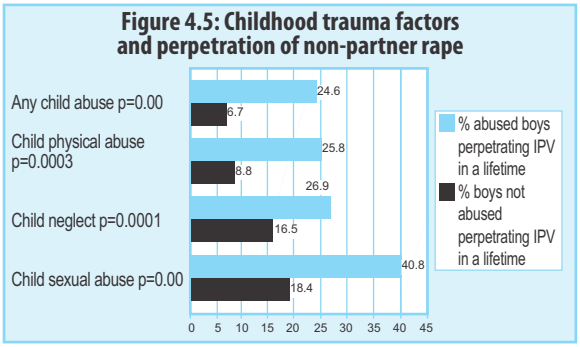


Figure 4.5 shows that there is a correlation between experience of the different forms of child abuse and rape perpetration (p=0.00). Two in every five (41%) men who experienced sexual abuse as children reported that they had raped women, while 18% of men who never experienced child sexual abuse reported that they had perpetrated rape. One in every four men who had been physically abused (26%) or neglected (27%) reported that they had perpetrated rape.

In the South African context, where the prevalence of sexual offences is higher than in other countries, these findings illustrate the importance of addressing child abuse and viewing it as a risk factor to intergenerational perpetuation of VAW. It is important to protect children's rights and create campaigns against child abuse that include boys.

Risk factors identified by "I" Story participants

Victims identified risk factors for violence that include alcohol abuse, cultural practices, perpetrator background, insecurity and jealousy.

Figure 4.6: Personal attitudes towards gender relations by women and men

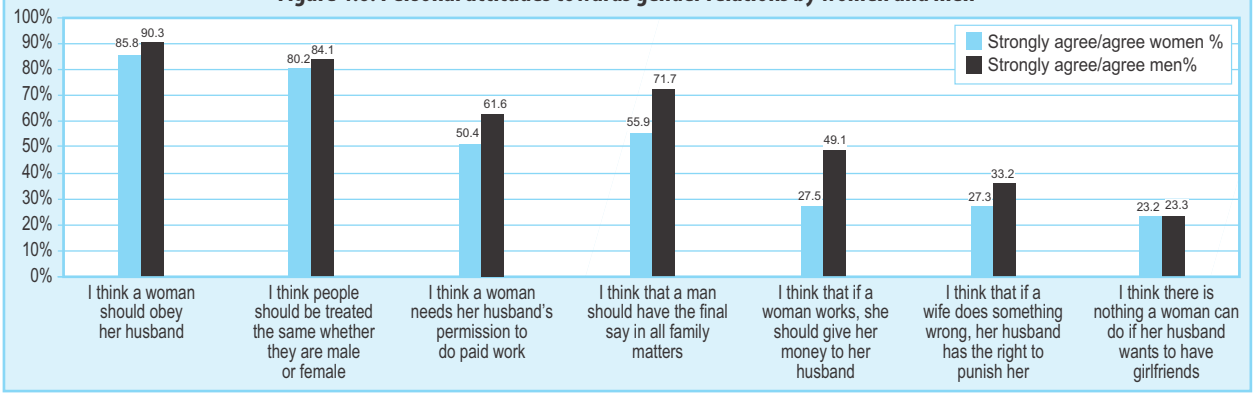


Figure 4.6 shows the responses of men and women to questions about gender relations. The majority of respondents said that both men and women should be treated equally. However, it is evident from the other responses that a conservative approach to gender relations in the home remains the norm. While men's views appear more conservative, women in Limpopo province also affirmed these attitudes. A majority of men (90%) said women should obey their husbands, husbands should have the final say (72%) and wives should obtain permission to pursue paid work (62%). A majority of women responded similarly, illustrating that patriarchal norms and values still have a hold on both sexes.

The findings also show that while patriarchal values remain dominant, a significant proportion of women and men have begun to challenge these values. For instance, 63% of women disagreed that if a woman works she must give her money to the husband or that a husband has the right to punish his wife if she does something he deems to be wrong. More than three quarters (75%) of men and women feel a woman has options if her husband cheats on her.

Figure 4.7: Women and men's perceptions of gender attitudes in their community

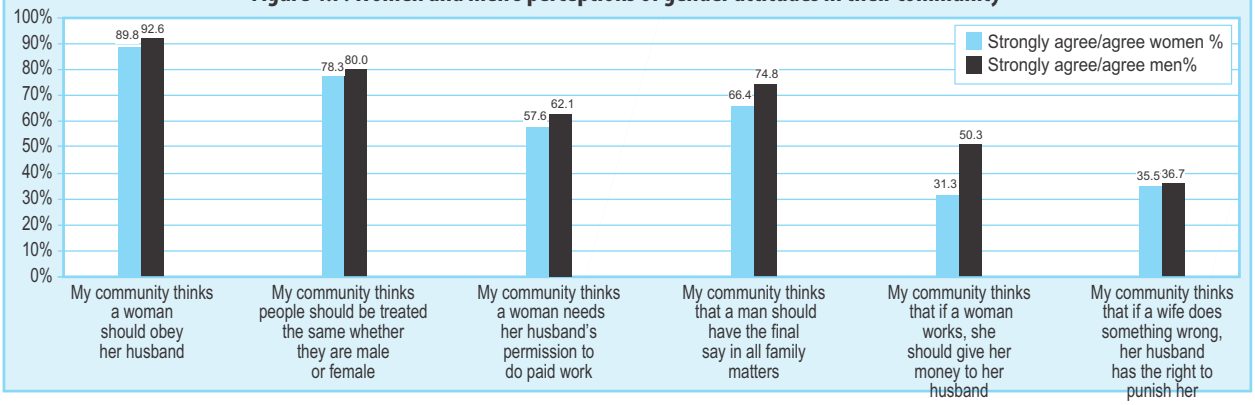


Figure 4.7 presents responses to questions on perceptions around gender relations at community level. These responses illustrate the prevailing attitudes about gender and women's place in society. Ninety percent of women and 93% of men perceive that their community believes a woman should obey her husband. More than half of both men and women affirmed that their community believes that a woman

needs her husband's permission to do paid work. Almost three quarters of men said that their community thinks a man should have the final say in the house, while half agreed that their community believes if a woman works she should give her money to her husband. However, more than three quarters of both men and women feel their community thinks people should be treated equally. This seems contradictory to the other responses, which uphold gender inequality.

The findings also show that changing negative attitudes about gender relations starts at the individual level; however, certain community structures can guide and inform individual perceptions and behaviour. Survey responses show that community attitudes to gender relations in the home differ and can be generally perceived to be more conservative than those expressed by individual participants. Higher proportions of men and women said they felt gender inequality exists at the community level. For this reason interventions should also aim to address societal beliefs and norms about gender equality.

Sexual entitlement in marriage and the legitimacy of violence

The notion of equating payment of lobola with purchasing property and wife "ownership" impacts sexual relations and the manner in which sex is negotiated between partners.

Figure 4.8: Personal attitudes about sexual entitlement in marriage and legitimacy of violence by women and men

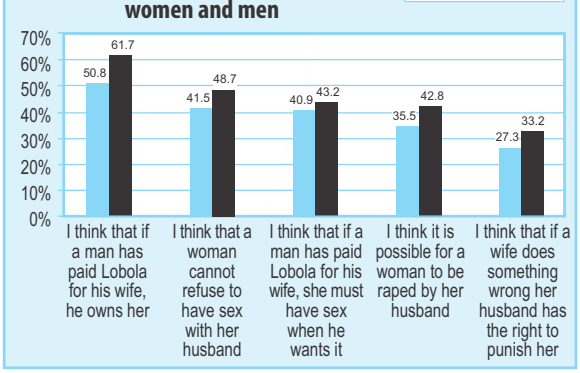


Figure 4.8 shows that while there is broad acceptance of wife ownership among men and women, there is significant disagreement about whether this ownership translates to sexual entitlement as well as the use of violence to control. More than half of both men (62%) and women (51%) agreed that paying lobola implies wife ownership. More than half of women (59%) and men (57%) disagreed that men should be entitled to force a woman to have sex following lobola payment. In other words, these women and men believe that a woman's right to consent, or withhold consent, to sex should not be nullified by the paying of lobola. It is also noteworthy that a significant proportion of respondents believe otherwise. In fact, a similar number of women and men said that if a man has paid lobola for his wife she must have sex with him whenever he feels like it. This illustrates that for many, lobola is a transaction which objectifies the woman.

The findings also show that the premise of marital rape is not yet well understood by both women and men. The majority of women (64%) and men (57%) disagreed that a man could be arrested and charged for raping his wife. This finding is somewhat contrary to the other views expressed around sexual entitlement.

Figure 4.9: Men and women's perceptions of attitudes about sexual entitlement in marriage and legitimacy of violence held by their community

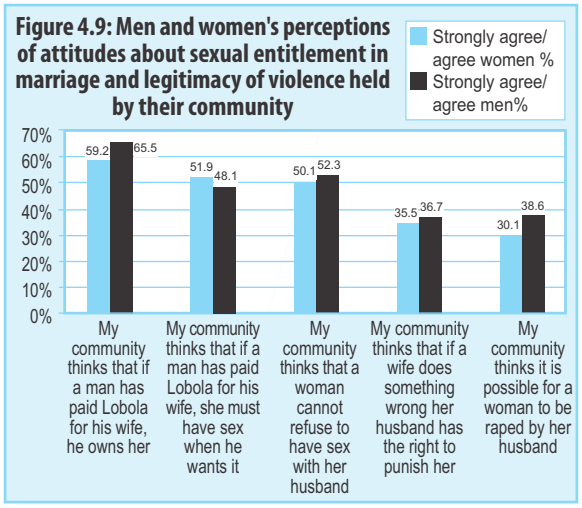


Figure 4.9 shows the responses to questions about community attitudes on issues of sexual entitlement

and legitimacy of the use of violence in marriage. Again it can be noted that in general, communities exhibit conservative attitudes about gender equality in the home. This is evidenced by the proportions of men and women who say their community believes when a man has paid lobola for his wife he owns her, and as such he can force her to have sex or punish her if she does something he deems wrong. Higher proportions of men and women think they are less conservative than the members of their community.

Findings from the "I" Stories

Of the 16 women's "I" Stories from Limpopo only four stories demonstrate how certain cultural norms upheld by a community can influence violence against women. The cultural practices identified as drivers of GBV include heir and son-preference, which often has the effect of encouraging men to be promiscuous; masculinity being amplified by men's ability to have multiple partners; and sexual entitlement following the traditional marriage. Traditionally, it is the woman who has to leave her family of origin. It is noteworthy that while societal values can uphold harmful cultural practices, allocating responsibility within spheres of influence that foster cultural or religious values can also help to end them. For example, one story demonstrated how traditional leadership is still highly esteemed within the society. As such, this can be used as a platform to instil change and foster good cultural practices such as respect for women.

Table 4.5: Changing societal norms over time

	***Three Provinces Study* pooled responses 1998 % Agreeing**	**Gender Links Northern Province (Limpopo) Strongly Agree/Agree %**
Gender relations in the home: control		
My community thinks that a woman should obey her husband	95.4	88.9
I think that a woman should obey her husband	84.0	85.8
My community thinks that if a woman works she should give her money to her husband	58.9	31.3
I think that if a woman works she should give her money to her husband	41.7	27.5
My community thinks that a man should have the final say in all family matters	75.1	66.4
I think that a man should have the final say in all family matters	53.1	55.9
My community thinks that there is nothing a woman can do if her husband wants to have girlfriends	48.6	33.0
I think that there is nothing a woman can do if her husband wants to have girlfriends	26.5	23.2
My community thinks that a woman needs her husband's permission to do paid work.	88.3	57.6
I think that a woman needs her husband's permission to do paid work	71.7	50.4

	Three Provinces Study pooled responses 1998 % Agreeing	Gender Links Northern Province (Limpopo) Strongly Agree/Agree %
Shared domestic work		34.7
My community thinks that men should share the work around the house with women such as doing dishes, cleaning and cooking	35.8	44.2
I think that men should share the work around the house with women such as doing dishes, cleaning and cooking	60.5	
Ownership		
My community thinks that if a man has paid Lobola for his wife, he owns her	80.8	50.8
I think that if a man has paid Lobola for his wife, he owns her	64.1	52.4
My community thinks that children belong to a man and his family	71.6	42.9
I think that children belong to a man and his family	51.0	
Sexual entitlement in marriage		51.9
My community thinks that if a man has paid Lobola for his wife, she must have sex when he wants it	76.0	40.9
I think that if a man has paid Lobola for his wife, she must have sex when he wants it	46.6	50.1
My community thinks that a woman cannot refuse to have sex with her husband.	63.5	41.5
I think that a woman cannot refuse to have sex with her husband	54.0	
Legitimacy of violence		35.5
My community thinks that if a wife does something wrong her husband has the right to punish her	58.1	27.3
I think that if a wife does something wrong her husband has the right to punish her	40.7	23.9
My community thinks that if a man beats you it shows that he loves you	41.7	17.2
I think that if a man beats you it shows that he loves you	25.4	

Table 4.5 compares the responses of women in Limpopo participating in the 1998 MRC Three Provinces Study and the responses of women in the GL 2012 study. Fourteen years have passed since researchers interviewed women in Limpopo, Mpumalanga and the Eastern Cape for the Three Province Study and asked about their personal attitudes towards gender relations and their perceptions of attitudes generally held in their community. Many interventions followed that research, among them campaigns with messages like "Real men do not abuse women" and the 16 Days of Activism campaigns.

Personal and community attitudes towards sexual entitlement in marriage have improved. However, community attitudes in relation to lobola and sex in marriage remain conservative, indicating a need for further advocacy on the issue of gender and marital sexual matters. Almost half of the respondents agreed that a man can have sex when he wants (51.9%) and that a woman cannot refuse him sex (50.1%).

Attitudes towards legitimacy of violence also changed. The community and personal attitudes show that there is recognition that violence does not indicate love or ascertain control. Women's perceived community attitudes show that men continue to be considered the head of the family. Personal attitudes on this matter increased slightly from 84% in the 1998 study to 85.8% in the Limpopo survey. The results indicate that in Limpopo, while men may be seen as the head of the family, this does not mean they have the right to abuse women sexually, physically or economically. The results also show that household work is still considered to be for women.

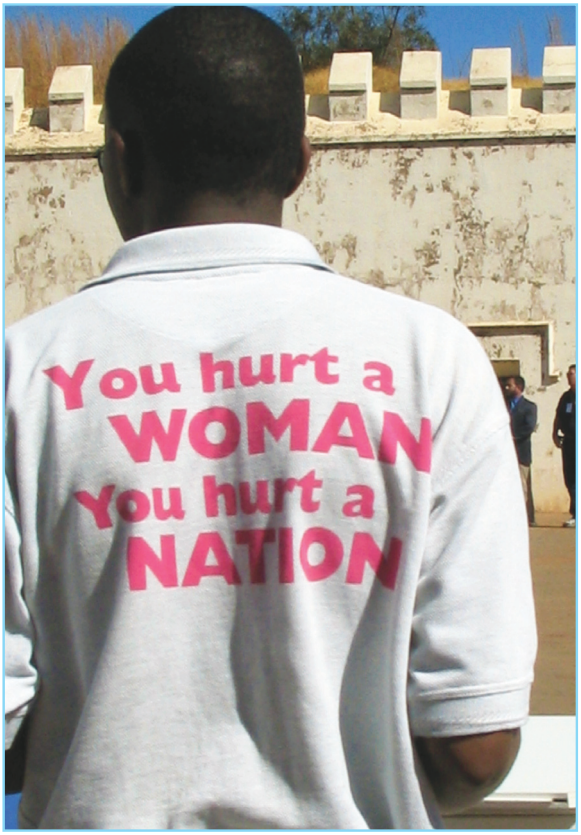
Conclusion

This chapter explored the individual, family/ relationship, community and societal factors that impact adult behaviours. Among the demographic factors, it did not establish an association between age and non-partner rape experience in the 12 months before the survey. This implies that all women remain vulnerable to non-partner rape. It also found that education levels do not correlate with rape perpetration or experience. However, employment status did correspond and findings show that unemployed men are more likely to perpetrate non-partner rape. Alcohol consumption and drug use also play a role in violence. Alcohol use is connected to women's experiences of IPV in the 12 months before the survey. Similarly, drinking alcohol and use of drugs is associated with IPV perpetration among men in the 12 months before the survey.

Previous studies have shown that child sexual abuse increases the risk of adult sexual re-victimisation or perpetration. This study found that men who had been physically or sexually abused, or neglected as children, are more likely to perpetrate IPV at least once in their lifetime. These findings provide evidence underscoring the need for child rehabilitation programmes for abused children and campaigns advocating for reduction of child abuse. Prevention of child abuse may ultimately contribute to prevention of IPV perpetration.

Although the majority of respondents said that both men and women should be treated equally, their other responses illustrate that society maintains a conservative view when it comes to gender relations. More than half of men and women believe that paying lobola entitles the man to ownership of his wife. Men's views tend to be more conservative than women's. It is also noted that community attitudes tend to be more conservative than attitudes at the individual level. As such, interventions should aim to address societal beliefs and norms around gender equality.

CHAPTER 5
EFFECTS OF VAW



Participant wearing a "You hurt a woman, You hurt a Nation" t-shirt at a women's day event in Johannesburg. *Photo by Colleen Lowe Morna*

Key facts

- Effects of GBV in the study include injuries, depression, suicidal thoughts, unwanted pregnancy, miscarriage and other pregnancy related complications and STI including HIV.
- Sixteen per cent of women who experienced physical abuse suffered injuries.
- Women who experienced IPV in their lifetime were more likely to be diagnosed with an STI than women who never experienced IPV in their lifetime.
- A significantly higher proportion of IPV and rape survivors reported a HIV positive status when compared to non survivors.
- Depression is the most common mental health problem among GBV survivors.
- One in six women who participated in the study, reported experiencing depression a week prior to the study.
- A higher proportion of IPV survivors or rape survivors attempted suicide in their lifetime than non survivors.
- More men than women blame or stigmatise rape survivors.



I (Mabricado) am a 25-year-old single woman. I don't have a job but I have studied heavy current electrical engineering. I was raped on 14 July 2012.

I was coming from Thohoyandou. I passed through a *Chesanyama* to grab some food as I was hungry. I then got a lift on a bakery van. When I got off the van it was late.

While I was walking, I saw a guy standing next to me holding a white piece of metal. That guy started pushing me. When I looked around there was another guy. Those guys started to beat me on my face. I began bleeding and was swollen.

While the one guy was busy raping me, the other one was busy beating me again and again. When the one was done raping me, then the one who was beating me began to rape me. The worst part of it was that they were not using condoms. I tried to fight back while they were raping me but because there were two of them they overpowered me and they used a piece of metal to beat me on my head which is why I couldn't run away.

Once they were done they took my phone, money, my keys and shoes. My hand was broken because one of the guys had twisted it. My head, breasts and back were sore and my face was swollen and bruised. After the incident I went home and slept in my pain. The following day I woke up and went to where they had raped me. I wanted to check if I could find my phone or shoes but I couldn't find them. Then I came back home and slept again. When my sister came back she found me in my bed crying. She asked me what had happened and I told her, "I was raped last night." She told me we must go to the police station to open a case against those guys. I told her that I don't know them and that even if they walked past me I don't think I would recognise them. She begged me but I refused to go there. She urged me to go to the hospital to get help and treatment but I refused. She went to talk to my younger sister and asked her to convince me to go to hospital. I eventually gave in.

First, I went to a clinic and told them what had happened and they referred me to the trauma centre because that was where I could get help. When I went there I met a victim advocate who helped me. She said I must have an HIV test first. When I was still at the trauma centre they advised me to open a case against those guys but I refused. The reason why I didn't want to open the case is that I didn't want the community to know that I was raped by two guys whom I don't even know. I also didn't want my mother to know about it.

After being raped, I was so angry at any men that I met. I even ended up breaking up with my boyfriend since I didn't tell him what happened and he found out from a friend. He broke up with me because he was ashamed of me and he thought I knew the guy who raped me and that was why I didn't want to open a case. I started having nightmares and I was always scared when I met with strangers or going to public places like parties. Sometimes I will just cry alone, blaming myself. I returned for more counselling at the trauma centre, which really helped me. My counsellor asked me to join a survivor workshop and it helped so much. I got support from my friends. I have found myself again.

This story of Mabricado is an account of a woman who finds herself helpless when she is attacked by two rapists. Like many rape victims, her boyfriend rejects her. She further tortures herself with self-blame, anger and hatred towards men. She eventually overcomes the experience through trauma counselling and with support from friends and family.

This chapter analyses women's responses about the effects of GBV. Researchers asked women questions on a range of indicators about their health, including on contraceptive use, condom use, HIV testing and results, sexually transmitted infections and aspects of mental health.

Abuse may result in damage to a woman's physical health and it could have long-term emotional impacts such as depression and insomnia. Women may also experience difficulty forming relationships with their children, whilst others may develop dependency on drugs or alcohol.[17] The stigma associated with being a victim produces other effects, including post-traumatic stress. Women experiencing these effects may not be aware they can be traced back to the abuse.

Physical injuries

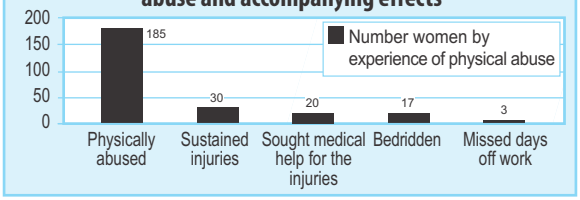
The effects of physical abuse include permanent disability such as blindness, deafness, epilepsy, loss of mobility, hospitalisation for broken bones, concussion, head and spinal injuries, gynaecological problems, losing an unborn baby or birth defects, infertility, treatment for broken teeth, cuts, headaches, concussion, bruises, pain, trauma and staying home so people don't see the bruises. Many women reported that the violence left them with physical scars that range with severity. For survivors, these scars become a source of shame, especially if they appear on the face or arms.[18]

Mulalo* who was raped shared *"I was in pain. My vagina was injured because the rapist forced himself into me even though I was tense. I had pain in my back from when he pushed me to the ground and raped me while I lay on top of thorny branches and stones. I was hurt emotionally because I never thought it would happen to me. After the incident I was always afraid to go on errands alone. I was scared that I will get raped again."*

This research associated experiences of GBV with immediate genital and bodily injuries. The survey asked women about the injuries they sustained as a result of physical abuse.

Figure 5.1 shows that 30 (16%) women who had been physically abused suffered injuries. Only 20 (11%) went to a health facility after sustaining these injuries. Seventeen (10%) had serious injuries which left them bedridden as a result of the assault. Three (2%) women had to take time off work because of the injuries sustained.

Figure 5.1 Women's experience of physical abuse and accompanying effects



Sexual and reproductive health

Effects of GBV reported in this study include pregnancy, miscarriage, sexually transmitted infections including HIV and pregnancy-related problems. The survey asked women about their experiences of sexually transmitted infections in their lifetime including questions about whether they had ulcers on the vagina or discoloured, smelly, itchy or uncomfortable discharge from the vagina. The survey also asked women whether a health worker had ever told them they had an STI.

Figure 5.2: Prevalence of symptoms of and diagnosis of STIs

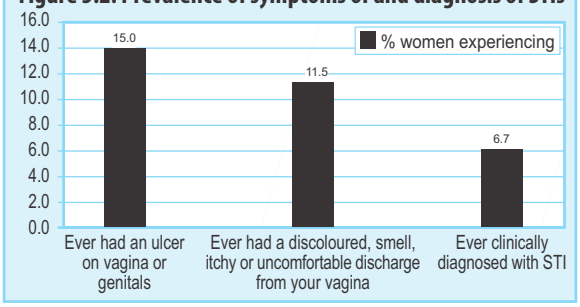


Figure 5.2 illustrates that 15% of women had a vaginal ulcer at some point in their lifetime while 12% experienced symptoms including a discoloured, smelly and itchy vaginal discharge. Seven percent of the women interviewed had been diagnosed with an STI at some point in their lifetime.

[17] Fox S .2003.Gender Based Violence and HIV/AIDS in South Africa. Centre for AIDS Development, Research and Evaluation.
[18] GL Speaking out can set you free.

Table 5.1: Association between symptoms of sexually transmitted infections and experience of IPV by women								
	Never experienced IPV	Ever experienced IPV	Never experienced physical IPV	Ever experienced physical IPV	Never experienced sexual IPV	Ever experienced sexual IPV	Never raped	Ever raped
Ever diagnosed of STI %	4.3	10.0	5.0	12.8	6.2	14.3	6.4	12.3
P value	0.006		0.00		0.06		0.2	

Table 5.1 shows that a significantly higher proportion of women who experienced physical IPV in their lifetime had also been diagnosed with an STI. The survey did not find a significant difference in the proportion of women who had been diagnosed with STIs between rape survivors and non survivors.

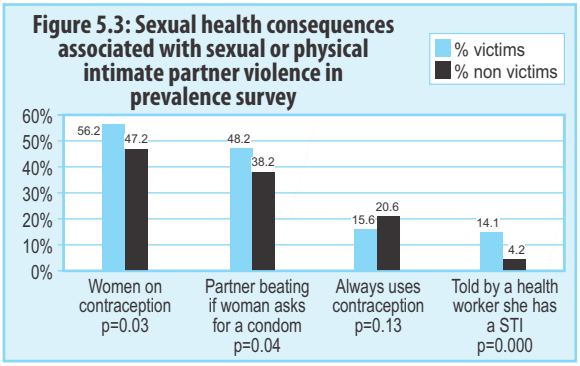


Figure 5.3 shows that a significantly higher proportion of women who experienced sexual or physical IPV used contraception at the time of the research, agreed that their partners would beat them for asking to use a condom and had been diagnosed with an STI. The survey also collected data on the prevalence of condom use. It found no differences in this measure between victims and non-victims of IPV.

HIV and AIDS

The impact of gender violence on risk of HIV infection has been well documented among South African women.[19,20] Previous research in different settings has shown positive association between GBV and HIV.

This study did not test for HIV but the survey asked women if they had tested for HIV and, if so, what result they obtained.

Table 5.2: HIV testing and results	
When did you last have an HIV test	**% Women**
Never tested	24.1
Last 12 months	64.4
2-5yrs ago	9.6
More than 5 years ago	1.9
HIV Status	
Negative	95.1
Positive	4.9

Table 5.2 shows that 24% of women had never been tested for HIV. The majority of women (64%) had been tested for HIV within the 12 months prior to taking the survey. Of the women who collected their test results, 5% reported an HIV-positive status.



It is essential to get tested for HIV within 72 hours after a sexual assault.
Photo by Gender Links

[19] Dunkle KL, Jewkes RK, Brown HC, Gray GE, McIntryre JA, Harlow SD. Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. Lancet. 2004 May 1;363(9419):1415-21.
[20] Jewkes R, Dunkle K, Nduna M, Shai N. Intimate partner violence, relationship gender power inequity, and incidence of HIV infection in young women in South Africa: a cohort study. The Lancet. 2010;367:41-8.

Figure 5.4: HIV-positive statuses among survivors and non-survivors

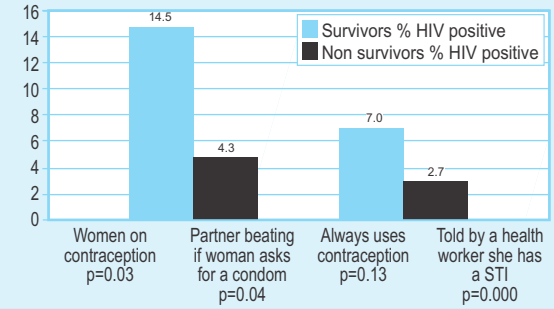


Figure 5.4 shows that a significantly higher proportion of IPV and rape survivors reported an HIV-positive status compared to non survivors. One in seven (15%) rape survivors and 7% of IPV survivors reported an HIV-positive status.

Mental health

The survey results also explored the serious and negative health impacts of GBV on women's mental health. Women in the study showed symptoms of mental health problems.

Figure 5.5: Mental health symptoms experienced by women

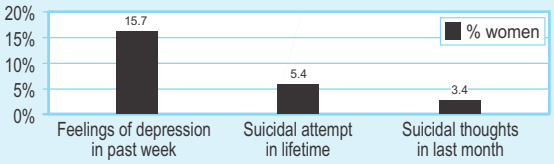


Figure 5.5 shows that one in six women (16%) participating in the study reported feeling depressed in the week before the survey. More than 5% of women attempted suicide in their lifetime and more than 3% experienced suicidal thoughts in the month before the survey.

Figure 5.6 illustrates the proportion of women who experienced physical or sexual intimate partner violence and had current mental health problems. Depression is the most common mental health problem among women who had experienced intimate partner violence. Thirty percent of survivors compared to 11% of non-survivors expressed high levels of depressive symptomatology at the time of interview. About a tenth of women who had been abused disclosed attempting suicide. This proportion is double that found among women who had not experienced physical or sexual IPV. Six percent of survivors compared to three percent of non-survivors experienced suicidal thoughts. These findings indicate a particularly high burden of mental ill health among women who have been sexually or otherwise abused by their partners.

Figure 5.6: Mental health consequences associated with sexual or physical intimate partner violence in prevalence survey

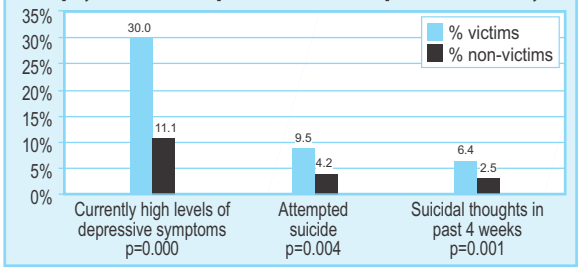


Figure 5.7 illustrates that women who have been raped by a non-partner also had very high levels of mental ill-health, especially when compared with women who had not been raped. In interpreting these results it is important to remember that many of the women who had not been raped had experienced intimate partner violence. More than a third of women who had been raped expressed very high levels of depressive symptomatology. A higher proportion of women who had been raped by a non-partner attempted suicide and had suicidal thoughts.

Figure 5.7: Mental health consequences associated with rape by non-partner in prevalence survey

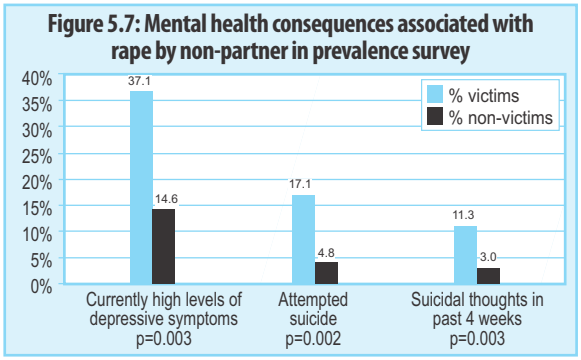
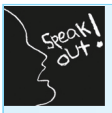


Table 5.3: Mental health consequences associated with physical IPV and rape experience in 12 months before the survey		
	% Non-survivors	% Non-survivors
IPV experience		
Feeling depressed P=0.002	15.0	31.2
Suicidal attempt in lifetime P=0.02	5.1	12.9
Suicidal thoughts P=0.000	2.3	18.4
Rape experience		
Feeling depressed P=0.03	15.5	41.3
Suicidal Attempt in lifetime P=0.02	5.2	28.7
Suicidal thoughts P=0.2	3.3	13.0

Table 5.3 shows that a significantly higher proportion of physical IPV and rape survivors attempted suicide in their lifetime and experienced recent symptoms of depression or suicidal thoughts ($p<0.05$). About a third (31%) of women who experienced physical IPV in the 12 months before the survey reported feeling depressed compared to 15% of women who did not experience physical IPV in a similar period. Nineteen percent of physical IPV survivors compared to 2% of non-survivors had suicidal thoughts. A higher proportion of rape survivors (41%) compared to non-survivors (16%) felt depressed. Twenty-nine percent of survivors attempted suicide and 13% had suicidal thoughts.



Tumela is a rape victim and student who spoke of the negative effects she suffered as a result of being raped, including emotional instability and crying spells.

"The rape incident has negatively affected me because my life changed and I became a different person. Before the incident I was outgoing but after it I became quiet and my classmates thought it was because I am pregnant. Sometimes my mind gets lost. One day in class (Grade 9) a teacher gave out class work for us to write. He asked each student to write the answers on the board in front of the class. He chose me to go first even though I was very shy because of what happened. I knew the right answer but I wrote the wrong thing. I wrote "body" instead of "day." The teacher became angry with me and he started insulting me and I began to cry. My classmates were surprised because they knew me as a person who doesn't care about others hurting my feelings - they thought I was a tougher person. The teacher then changed his way, he called me and said he realised that I look like someone who has a problem. I explained what had happened to me and from then on the teacher was careful to be kind to me. He tried to help me in any way so that I would be able to deal with what had happened. I kept my rape story a secret and have only told my mum, neighbour, my best friend and teacher. I didn't want my boyfriend to find out, that's why I kept it a secret because if other people knew they would have told him. Even now he doesn't know about it, he just thinks that I opened a case against a person who had beaten me. The rape has caused me a lot of pain and stress. When I think about it I just cry. During exams I wasn't able to write answers and could only copy the questions. When I am with other friends my age I get angry and insult them easily. I tried to kill myself by taking a lot of tablets. I didn't eat and started losing weight.

The results from this study show high prevalence of mental health problems among women who experienced GBV. This is indicative of the long-term and ongoing effects of GBV on women's lives, which is often not considered or addressed. There is a gap in the current health sector response that fails to meet women's mental health needs. It is essential that services meet abused women's needs for psychological support and, where indicated, for treatment of mental health problems.

Stigma and secondary victimisation

One of the effects of rape is that women can be blamed for it and condemned by their communities. Apart from being blamed, there is stigma or labelling attached to those who have been raped. Women and men participating in the survey responded to questions about their personal views of rape survivors as well as their perceived view of how their community sees rape survivors.

Figure 5.8 Personal and community attitudes about rape by men and women

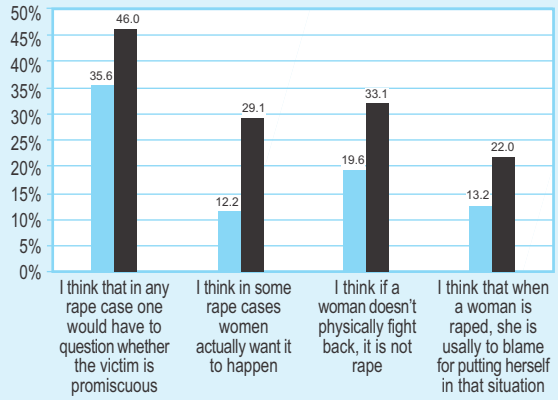


Figure 5.8 shows that a greater proportion of men exhibit attitudes that blame and stigmatise rape survivors. Almost half the men (46%) believed that rape survivors may have been promiscuous, 29% said in some cases women wanted it to happen and 22% said the survivors put themselves into compromising situations. A third of men (33%) said if women did not fight back then they had not actually been raped.

The negative attitudes indicate an increased likelihood that victims will be blamed and face stigma.

Some rape survivors have not spoken out of fear of stigma. Mulalo wrote about her fear that her community would discriminate against her, but in the end they accommodated her.



When I'm alone I wonder if other people know that I've been raped. The medication that I was given made me vomit when I tried to eat. It no longer feels like my body. When I see people laughing, in my mind I think that they are laughing at me because I was raped. I lost weight because of this problem of not accepting what happened to me. I even thought of committing suicide but it was not easy. I couldn't do that because I know God doesn't want me to kill myself. I find strength in prayer and going to church. When I am at church I feel free and I feel that Jesus is present with me and I am really alive. I am now able to sit down with other people and talk about what happened because I have accepted that. People in the community helped by searching for the man and even now they are still trying to help and they are not discriminating against me at all. They accept me even as they did before I was raped.

Conclusion

This chapter highlighted women's responses to GBV in relation to mental health, contraceptive use, HIV testing and STI history.

GBV compromises women's mental health and the results show that women who have experienced violence are more likely to face mental health challenges. Depression is the most common mental health issue. There is a need to strengthen support systems for victims, including such as counselling, therapy and medical diagnosis and treatment.

Consistent with other studies on VAW, this research found women who have experienced violence are more likely to be HIV-positive or have an STI. This

could be explained by the results of the study which show that survivors have often been beaten if they ask for condom use. These women do not have the power to negotiate for condom use to protect themselves from sexually transmitted infections, including HIV.

High levels of stigmatisation exist for rape survivors. It is important to target entire communities, especially men, in raising awareness about VAW. This will help tackle the stigmatisation of rape survivors and encourage more women to open up about their experiences. This will enable survivors to better overcome the ordeal, thereby promoting their mental health.

CHAPTER 6
RESPONSE



Limpopo SAPS take to the streets to protest against escalating crime against women. *Photo courtesy Google Images*

Key facts

- Over a third (40%) of all sexual offences reported to SAPS during 2011-2012 period involved children and nearly half (48.5%) involved adult women as victims.
- Rape accounted for almost three-quarters of all sexual offences (74.5%) recorded nationally during the same period.
- In Limpopo, rape was the most dominant type of sexual offence with a 5% increase in reported cases from the year 2010/2011.Overall, Limpopo experienced a 16% increase in total sexual offences in the same period
- The number of registered names of sex offenders on the NRSO increased from 978 in 2011 to 2 340 in 2012
- Average conviction rate of sexual offences prosecuted at sites linked to TCCs, dropped from 63% to 60.7% in
- At the time of study implementation, there were 30 TCCs nationwide and four in Limpopo. Only two of Limpopo TCCs are fully operational.



I (Prudance) am a 22-year-old woman. On 31 May 2012 I was coming from Levubu to collect money from my mother's younger sister to buy some food. I took a taxi to Zwikwengani. When I got to Vuwani taxi rank there were no taxis. I waited with others until it got dark. Around 6pm a taxi going to Tshakhuma passed by so we got into it. When I got out at the bus stop it was around 6:30pm and it was dark. Before crossing the road there, a taxi from Vuwani going to Thohoyandou stopped and a woman got out of that taxi. Suddenly the woman started to run away holding her handbag tightly and two men that had been standing next to the taxi chased after her. When I was about to cross the road I saw the men coming toward me saying, "Let's help her to carry her things."

One of the men pulled out a knife and pointed it at my chest while the other man took everything that I was holding and said, "We are not going to any house, we are going to the bush. Don't scream otherwise we will stab and kill you." I kept quiet because I was scared. They dragged me into the bush and said that they needed money. Because I didn't want them to steal it, I had already thrown it on the ground as we were walking. I gave them my handbag to search. When they found nothing, the one man said, "It will be better if I kill her." The other man said he wanted to rape me.

He told me to take off my clothes but I refused. I offered to take him back to where I dropped the money or take them to an ATM to withdraw money from my bank card. One of the men took the card but the other said to me again, "I want to rape you." He threatened me by saying, "Do I have to stab you to make you take your clothes off?"

I cooperated and took off my trousers. He laid me on top of my trousers and raped me. I begged him, "Don't ejaculate inside of me," and he said, "You don't tell me that! Are you scared of getting pregnant or getting diseases? It doesn't work like that." When he was done, he called the other man to also rape me. After the second man was done, he said he was going to find the cash I'd thrown out on the road. As he left, he said if he did not find the money he would kill me and that if I tried to run away he would look for me until he found me. The one who raped me first raped me again. When he was done I asked to please go and relieve myself.

I grabbed my phone and ran. He was angry and chased after me with a knife. When he caught me he slapped me; I kicked him and we started fighting. He beat me on my face and strangled me. He put his knife to my throat and said, "I will kill you, even though it wasn't my first intention." He then grabbed me and took me back to where they had already raped me three times.

The other man returned and said I had no money on my bank card. He accused me of playing with them. They were going to kill me for that. The other man agreed and said I had to pay for trying to run away. They then both raped me again one after the other. That means the one who was holding a knife raped me three times and the other one raped me twice which means I was raped five times.

I ran to the nearest house and sent a please-call-me sms to my mother and aunt. When my mother arrived with the police, I started crying. The police made me feel bad, asking, "Where were you coming from at night? Were you not aware that it was getting late? Now see what these people have done to you." I tried to explain what had happened but they said I must go to Tshilidzini Hospital trauma centre. My neck was bruised and sore from when they strangled me and I had bitten my tongue while they beat me. My face was swollen. When we got there a policewoman took my statement and a doctor examined me. They told my mom to go home, but she refused and said she would sleep there on a chair. I slept at the trauma centre. A victim advocate woke me up in the morning and asked me to take a bath; she treated me very well.

Another police officer arrived to take my statement again, as he was supposed to be investigating the case. The following day the police came to my home

because I had heard from other girls that they knew the rapists. I remember them well. One of them had a dark complexion, short hair and wasn't very tall. I hadn't seen him before. He was wearing a black jacket and colour faded jeans and sneakers. The other man was tall with a dark complexion and was wearing a black jacket, orange t-shirt and dark trousers and takkies.

I was hurt when the police officer said there was no evidence, that many people can look similar, and even clothes can look the same. When I told them this new bit of evidence, they said I must go and ask around and pretend as if I love the tall guy so that the police can find him. They didn't write anything down. Since then the police have never called me or returned. After the incident, I became very scared, especially when I think that those guys might come for me at home. I am very scared if I hear a sound in the house, even if its afternoon. At night I would lie in bed awake. I'm scared to attend parties and visit friends or go to the shops in the dark. If I go to town I get scared. I am always alert and looking around. I feel as though I might see the two rapists again.

After what happened to me, the father of my child showed his support and love. He didn't want to leave me and he took time off from work to be with me. My family also stood by me and cared for me. I started spending more time at church so that I could take care of my soul. I lost hope of getting justice because the police never updated me of any progress. I still hate most men. I respond to them in anger and also get scared when I see people with similar features to the two men who raped me.

I received counselling at Tshilidzini trauma centre so then I felt freer and stood up as a woman. I also got support when the pastor from my church came to visit and prayed for me. It encouraged me to see that there is still love. Even the ward counsellor came to visit me and had time to talk to me. My friends have been supportive. I also found a support group where we talk about our experiences of rape. I learned that if somebody comes across a problem we need to help that person, as people have helped me.

Prudance's story typifies the type of daily and on-going ordeal faced by many women after they have been raped. Enduring rape, assault, scorn and robbery at the hands of two men, she does not receive much help from the police. Like many survivors of crime, Prudance loses faith in the justice system. She, however, finds solace in, and help from, a supportive family, the church, friends and Tshilidzini Trauma Centre.

This chapter explores the various legal provisions and support systems that exist to protect the rights of women and promote gender equality. Ensuring gender equality is vital to the development of a country.

Ratification to international and regional instruments

One of the indicators that measures political commitment to end VAW is a country's ratification and adoption of legal instruments and the existence of institutional systems which facilitate the elimination of VAW. South Africa is signatory to several conventions to combat gender-based violence, including the Convention on the Elimination of Discrimination against Women (CEDAW), the Beijing Platform for Action (BPA) and the protocol to the African Charter on Human and Peoples Rights on the Rights of Women in Africa.

Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)

The CEDAW is an international bill of rights for women. It describes what constitutes discrimination against women and sets an agenda to end all forms of discrimination against women. The South African Parliament ratified the United Nations Convention on the Elimination of All Forms of Discrimination against Women in 1995.

South African Declaration on Gender and Development

The heads of state of the Southern African Development Community (SADC), including South Africa, signed a declaration committing their countries

to embedding gender firmly into the agenda of their Programme of Action. This includes repealing and reforming all laws and changing social practices which subject women to discrimination. The declaration further commits to protect and promote the human rights of women and recognise, protect and promote the reproductive and sexual rights of women and the girl child as well as take measures to prevent and deal with the increasing levels of violence against women.

United Nations Declaration of Basic Principle of Justice for Victims of Crime and Abuse of Power

The declaration is based on the philosophy that victims should be adequately recognised and treated with respect and dignity. Victims can access all mechanisms of justice and should have prompt redress for the harm and loss suffered. They are also entitled to receive adequate specialised assistance in dealing with emotional trauma and other problems caused by the impact of victimisation.

Apart from the ratification of regional and international frameworks, an effective legal instrument to end violence against women demonstrates a government's commitment to uphold human rights. In South Africa, several laws address VAW in public and private life.

Domestic Violence Act (DVA)

The DVA No.116 of 1998 targets violence in the home. Such violence exists in a wide range of domestic relationships, including between individuals in a romantic relationship, whether married or not, family members, and persons residing, or who have recently resided, together in a common household. The DVA defines a "complainant" as an individual in a domestic relationship who is suffering harm.

The broad and all-encompassing definition of domestic violence to include all forms of relationships within a household potentially poses a challenge when analysing SAPS and court data to extract the true extent of VAW. One of the immediate and positive outcomes of this study has been a commitment from SAPS to include a relationship category in its crime registration database.

Sexual Offences Act (SOA)

In compliance with constitutional provisions, CEDAW and BPA obligations, South Africa introduced the Criminal Law (Sexual Offences and Related Matters) Amendment Act 2007 (Act No 32 of 2007) (SOA), which makes it an offence to have sexual intercourse with a girl younger than 16. SOA received approval from stakeholders as it indicated a commitment to be less limiting in the application of the law on sexual assault. It expands the definition of rape to encompass rape of men and use of any object in sexually assaulting another person. The framework also specifies legal procedures to ensure the protection of vulnerable witnesses within the criminal trial and the broader criminal justice process.

Although stakeholders welcomed SOA from its inception to the period under review, the true extent of sexual offences reported has been unclear because of the inclusion of sex work and pornography under this crime category. SAPS has again committed to addressing this challenge by separating sexual offences reported by survivors from sexual offences solicited by police action in its annual Crime Situation Report.

Evaluation of DVA and SOA implementation

Stakeholders have identified gaps in the implementation of these acts. One of the main issues is inadequate resourcing allocated towards their implementation. According to research undertaken by Tshwaranang Legal Aid Centre (TLAC), several police stations do not have the required resources to carry out the procedures stipulated by the acts. It is also evident that key players including police remain ignorant about the fundamental issues pertaining to these acts. When it comes to delegating responsibilities there is a loophole in the DVA which causes ambiguity. The DVA places responsibility on only one department, the SAPS, yet it places no corresponding legal obligation on other relevant stakeholders such as the DSD and the Department of Health (DoH). Although the DSD and DoH play ancillary roles and have policies within their departments to respond to victims of violence and sexual offences, there is a need for further legislative

enforcement in order for implementation to be effective (TLAC 2010).

Record keeping of domestic violence cases
All domestic violence incidents reported to police must be recorded in the Domestic Violence Register. At present no figures exist regarding the number of domestic violence cases reported to the service because there is no such crime as "domestic violence." Incidents of domestic violence have until now been included amongst figures relating to assault to inflict grievous bodily harm, common assault, rape, attempted murder, pointing of a firearm, etc. The introduction of this register will ensure that this system is altered.[21]

Policies

Service Charter and Minimum Standards for Victims of Crime in South Africa

In 2004, the cabinet approved a Service Charter for Victims of Crime in South Africa as well as Minimum Standards on Services for Victims of Crime. It is intended to assist in the implementation of the Victims' Charter. The Victims' Charter and Minimum Standards provide an important framework for the consolidation of all laws and policies in relation to the rights of and services provided to victims of crime and violence. It is intended that they promote excellence in service delivery thus promoting client satisfaction with the services delivered.[22]

National Policy Statement for Victim Empowerment

These National Policy Guidelines provide the regulatory framework for promoting and upholding the rights of the victims of crime and violence in order to prevent re-victimisation within the criminal justice and associated systems. In addition, it provides a framework to guide and inform the provision of integrated and multi-disciplinary services aimed at addressing the diverse needs of victims of crime and violence effectively and efficiently.[23]

Lawmakers developed the Integrated Strategic Framework for the Prevention of Injury and Violence (i.e. interpersonal violence) in November 2011. It incorporates a plan for response to violence. The framework development included a multisectoral approach with other national departments, provincial departments of health, civil society organisations and academic and research institutions, including the Medical Research Council. This strategy enhances the capacity to reduce the high burden of injury and trauma, especially from road accidents, interpersonal violence and violence against women and children. The technological and professional staff capacity of the forensic laboratories has been increased to support the justice system.[24]

Public services

Several government departments and civil society organisations (CSOs) have created structures to provide services to survivors of VAW. Most government departments have been oriented towards response and support, while CSOs have created support and prevention campaigns. Client data is collected as a routine exercise whenever survivors access these services. Researchers obtained data on access to services for this chapter by liaising with respective departments and organisations. In instances where service providers did not make information readily available, the research made use of past annual reports and information from organisational websites. This chapter mainly focuses on the SAPS and DOJ&CD work in curbing VAW.

South African Police Services (SAPS)

According to the Domestic Violence Act (DVA) it is the responsibility of every member of the SAPS to avail him or herself at the scene of an incident of domestic violence in as little time as reasonably possible or when the incident of domestic violence is reported. They should then render such assistance

[21] http://www.saps.gov.za/org_profiles/core_function_components/fcs/establish.htm
[22] http://www.npa.gov.za/files/Victims%20charter.pdf
[23] http://www.npa.gov.za/files/Victims%20charter.pdf
[24] (Department of health report 2011-2012) http://www.doh.gov.za/docs/reports/annual/2012/Health_Annual_Report_2011-12.pdf

to the complainant as may be required in the circumstances. This includes assisting or making arrangements for the complainant to find a suitable shelter and obtain medical treatment if necessary.

An individual may lodge a complaint with the Independent Police Investigative Directorate (IPID) if they feel that any member(s) of the SAPS failed to comply with the provisions of DVA. Any interested persons, victims of domestic violence and non-governmental organisations may lodge the complaint. Some of the failures may include failure to:

- Effect arrest against the perpetrator;
- Assist the complainant to open a case, find a suitable shelter, obtain medical treatment, or to accompany the complainant to collect personal property and seize any dangerous weapon from the abuser;
- Advise the complainant of options, such as failure to advise the complainant to lay criminal charges or to apply for a protection order, or both; and
- Serve the respondent with a subpoena to appear in court.

Specialised units within SAPS

In order to better respond to VAW, SAPS has created specialised units whose sole responsibility is to address issues of domestic violence at police station level.

The Child Protection Unit

Police established this unit to prevent and combat crimes against children. It deals with cases of rape, incest and sexual exploitation among many others. Government has demonstrated leadership in ensuring that the constitution, legislation, policies and international instruments provide statutory protection towards ensuring a better life for children. The Children's Act of 2005 sets out the principles relating to the care and protection of children and defines related parental responsibilities and rights. It is important that children know and understand their rights. The act sets out general principles and promotes the best interests of the child.[25]

In recent years police identified a need to expand the sensitive service rendered to children, to adult victims of family violence and sexual offences. This led to the establishment of the Family Violence, Child Protection and Sexual Offences Unit (FCS). Its objective is to transform all Child Protection Units and establish FCS units, depending on available resources and the occurrence of crimes policed by the FCS unit.



Police woman at International Women's Day, South Africa.
Photo by Gender Links

Family violence, child protection and sexual offences (FCS)

The FCS unit's primary goal is to make the public aware of the existence of relevant crimes, the role of the public in preventing and combating these crimes and the role of the Child Protection Unit/FCS Unit. Awareness is fostered by multi-disciplinary meetings, media coverage and lectures and talks at schools, universities and church organisations. Members of the unit present these to people of all ages, ranging from children to adults.

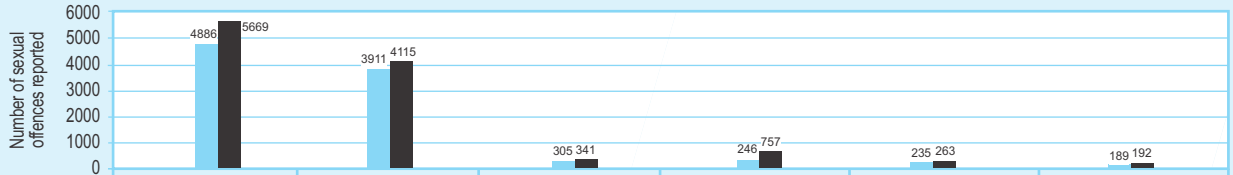
[25] http://www.saps.gov.za/org_profiles/core_function_components/fcs/establish.htm

FCS units have been reintroduced in all 176 SAPS clusters across the nine provinces. Police have placed 2155 detectives at these units and issued them with 1276 vehicles. Previously, the FCS units consisted of only 1864 detectives.[26] Frank et al (2009) conducted an assessment of FCS service provision in South Africa with the specific objective of assessing the impact of the restructuring process of 2006. The study found that restructuring had done little to improve service delivery to victims of violence. It identified several gaps, noting that the restructuring resulted in the placement of FCS staff in service-delivery positions and they had: (1) not been suitably trained, (2) were not suitably experienced, (3) did not undergo special screening or selection, (4) had not specifically elected to work on FCS cases and (5) did not have some of the basic requirements to undertake the job.[26]

National prevalence of sexual offences against women and children based on SAPS statistics 2011/2012

The country's overall documented sexual offence rate decreased by 3.7% from 2011 to 2012. Rape, according to the new, more inclusive definition that covers vaginal, oral and anal penetration, accounted for three-quarters of all sexual offences (74.5%) recorded nationally. This crime decreased by 3% from the previous year (SAPS National Crime Statistics Annual Report 2011/2012). More than a third (40%) of all sexual offences involved children and nearly half (48.5%) involved adult women as victims.

Figure 6.1: Changes in the overall sexual offences in Limpopo between 2011 and 2012



	Total sexual offences	Rape	Attempted sexual offences	Sexual offences detected by police	Sexual assault	Other contact sexual offences
2010/2011	4886	3911	305	246	235	189
2011/2012	5669	4115	341	757	263	192

Source: SAPS National Crime Statistics Annual Report 2011/2012.

Provincial

Figure 6.1 shows the different forms of sexual offences reported in 2012 in Limpopo. The number of cases reported varied among the different forms of sexual offences. Rape dominated with 4115 cases (73%) followed by Sexual offences detected by police, attempted sexual offences and sexual assault (SAPS National Crime Statistics Annual Report 2011/2012).

According to Figure 6.1, police logged a marked increase in sexual offences incidence detected by police, which rose by 208%. They also documented a 12% increase in the number of attempted sexual assaults and in other sexual offences, which increased by 1.6%. Overall, Limpopo experienced a 16% increase in total sexual offences (SAPS National Crime Statistics Annual Report 2011/2012).

[26] http://www.rapcan.org.za/File_uploads/Resources/FCS_report_text_web1.pdf

Table 6.1: Limpopo sexual offences incidence rates for females 2012			
	Female population	Female population	Incidence females
Sexual assault	263	2 012 898	0.013
Other contact sexual offences	192	2 012 898	0.010
Sexual offences detected by police	757	2 012 898	0.038
Attempted sexual offences	341	2 012 898	0.017
Rape	4115	2 012 898	0.204
Total sexual offences	5669	2 012 898	0.282

The incidence rate for the adult female population is 0.28, which means that three in every 1000 females experienced some form of sexual offence in 2012. This finding is relatively low compared to figures obtained from the GL Limpopo survey.

The role of the Independent Complaints Directorate (ICD) in the implementation of the DVA

Since its inception, the Independent Complaints Directorate (ICD) within SAPS has been responsible for monitoring the implementation of the DVA. Any interested persons, victims of domestic violence and non-governmental organisations could lodge a complaint with the Independent Police Investigative Directorate (IPID) if they felt that any member(s) of the SAPS failed to comply with the provisions of DVA. Such groups lodged various types of non-compliance cases, including but not limited to: failure to arrest the alleged transgressor; failure to open a docket and refer the matter to the prosecution; failure to advise complainants of options (e.g. to lay a criminal charge or apply for a protection order or both); and failure to keep a copy of the protection order after it had been obtained from court. However, as the IPID Act, Act 1 of 2011 came into effect on 1 April 2012, the IPID no longer has a mandate to deal with any domestic violence related non-compliance matters. This now falls under the Secretariat for Police.[27]

National

The ICD over the years experienced constant challenges in implementing the DVA. According to its last report to the parliament, its major challenge involved maintaining an acceptable level of regulatory compliance in terms of administrative abilities and record keeping in line with the DVA and National Instructions.

Nationally, the ICD received a total of 67 cases of alleged non-compliance with the DVA from all provinces for the period July 2011 to March 2012. Most non-compliance matters occurred in the Western Cape.



A policewoman attends a take back the night march in Johannesburg in 2010. *Photo by Colleen Lowe Morna*

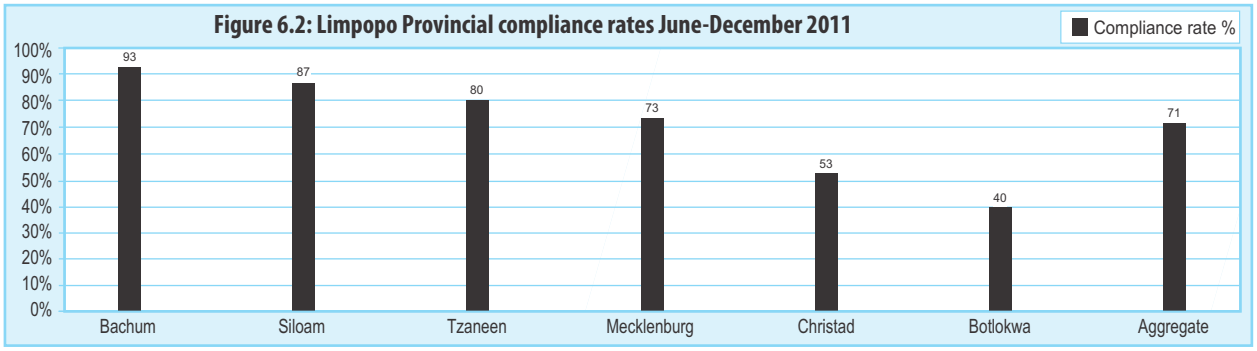
[27] http://www.ipid.gov.za/documents/report_released/dva_reports/2010-2011/ICD%20-%20DVA%20%20July%202011%20-%20March%202012.pdf

Provincial

Limpopo received no complaints of non-compliance with the DVA and SAPS received no application for exemption for the period July 2011 to March 2012. During that same period the ICD either organised or attended 28 awareness campaigns at which its members presented on the ICDs mandate and DVA as well as its new mandate as IPID. Community members attended these campaigns.

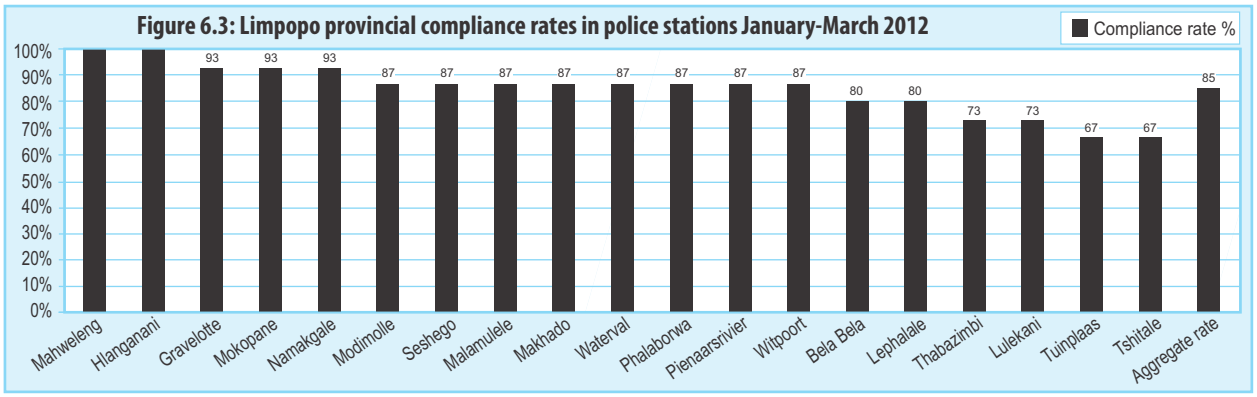
The Limpopo ICD provincial office audited some police stations to determine the level of compliance with the DVA and the National Instruction. Part of the audit included:

- An inspection of the SAP 508(a) and (b) registers; ensuring the Community Service Centre had copies of the DVA available;
- Ensuring that police had a list of service providers in the event that a victim of domestic violence needed one; and
- Auditors inspected victim-friendly facilities to ensure police could deal with matters of domestic violence.



Source: Department of ICD DVA Report: July 2011-March 2012.

Figure 6.2 shows the compliance rates of the six police stations audited between June and December 2011 in Limpopo. At 93%, Bachum recorded the highest rate of compliance followed by Siloam at 87%, Tzaneen 80% and Mecklenburg at 73%. Ohristad and Botlokwa police stations recorded the lowest compliance rates at 53% and 40% respectively.



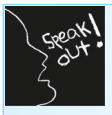
Source: Department of ICD DVA Report: July 2011-March 2012.

Figure 6.3 shows results from audits undertaken between January and March 2012 in Limpopo. Auditors assessed 19 police stations during this period. Of these only two, Mahweleng and Hlanganani, fully complied with the DVA and National Instruction.

Some of the findings of non-compliance included:

- No Domestic Violence Register, SAPS 508(b) in CSC;
- No SAPS forms 508(a) available in CSC;
- Responses to domestic violence incidents not recorded on SAPS forms 508(a);
- The SAPS 206 of members not maintained;
- Monthly procedures of File 39/4/2/3 on DVA incidents not maintained;
- Procedures of SAPS 10 on DVA not thoroughly maintained;
- Protection orders not served (no zero outstanding protection orders);
- Copies of protection orders received not filed;
- Copies of warrants of arrest received not filed; and
- Copies of warrants of arrest received not filed.[28]

Qualitative excerpts on SAPS response from survivor accounts



On 14 August 2012, I (Thandi) was watching TV at home with my child around 7pm. While I was sitting there my boyfriend Thabo arrived home and started talking to our child. While we were still sitting there, Thabo got a message on his phone. He said he was going out and would be back. After some time I went out to buy airtime at the spaza shop. When I got there I found Thabo standing at a rental house with another lady that I knew.

I asked Thabo what he was doing there so late at night. He said, "You don't have to ask me what I want, in fact you are disturbing me and I will beat you." I then went back home and I just sat there. He came back and he started shouting and then I shouted back at him. He took his phone and showed me that he has a woman who is pregnant and he wants to marry her. I took that phone and broke it. He also took mine and did the same thing. He told me I should leave the house and leave his child. I told him I can't go and leave my child behind. He shouted, "I didn't even marry you - there's another woman I want to marry."

I left and went to his sister Shawn's house and told her that Thabo said I should leave and it's late at night and I don't know what to do. Shawn gave me her phone to call the police. I told the police that I was chased away by my man and it's dark and I don't know what to do. The police said I should wait at the café and they would come and fetch me there. They didn't take long to arrive and said I should get into the van and they would take me to Tshilidzini Hospital's trauma centre where I could sleep for the night. When I arrived there I explained what had happened and they prepared food for me and my child. They said that the next day they would call a van to take me to my father's home and they wrote a letter to say that on Monday I should come back to apply for a protection order.

I told my father that Thabo chased me out of our house and so my dad said I should come back home and stay with them. My father said, "It's no problem."

On Monday 16 August 2012 I woke up in the morning and I went to the police to apply for a protection order and to ask for them to help me to collect my belongings from the house. They wrote a protection order, gave it to me and said Thabo should sign it. They called a police van and took me to Thabo's house but we couldn't find him there.

On 17 August 2012 I phoned my aunt and asked her for money to hire a car. My aunt said that there is no problem, I can get a car and fetch everything and she would pay for it. I went to Thabo's place in the car, packed all of my belongings and then left. When I got home I found my aunt waiting for me and she paid the driver. She told me not to cry

[28] http://www.ipid.gov.za/documents/report_released/dva_reports/2010-2011/ICD%20-%20DVA%20%20July%202011%20-%20March%202012.pdf

and not to go back again because Thabo might end up killing me. She said I should go back to school because marriage won't give me anything and I agreed with her.

Since we separated I feel relieved because I no longer have a problem. I have learned a lot and I wouldn't get into that kind of relationship again because he didn't want me to get a job. He said he doesn't like working women. He didn't want me to have friends. He would say that a married woman doesn't have friends. He would say that I don't have to leave the yard because friends would gossip and they break up families.

While Thandi's story is positive, other women wrote about being unsatisfied with the police response they received.

Lorain said: "The case didn't progress because my husband and I were insulted by a Shangaan police officer from Sibasa. They told us there was no case because my husband didn't come with a wife from his country and that they don't deal with things that happen at the shebeens. So the case ended. Even though I have since seen the man who raped me, I am not interested in talking to him."

Angel Keketso said: "In the end he wasn't arrested. The case was stolen by someone at the police station. Even now he is still at home. When I went to the police station to ask about the case the police said: 'Your docket is not available maybe someone took it.'"

National Department of Justice and Constitutional Development (DOJ & CD)

The *Department of Justice and Constitutional Development* is committed to supporting and promoting the rights of victims of domestic violence, especially women, children and the elderly, through the courts and criminal-justice processes. The department assists victims through the Victim Empowerment Programme (VEP), led by the *Department of Social Development*, which aims to improve victims' circumstances and quality of life.

DOJ&CD initiatives to respond to GBV related matters include the following:

- Development of JCPS Domestic Violence Strategy to improve coordination of services (the draft strategy is in the process of submission and approval by the JCPS Cluster Directors-General);
- Development of Prevention Strategy;
- Capacitating courts, especially large courts such as Johannesburg Family Court;
- Development of Braille awareness-raising material; and
- Specialised training with Justice College and the NPA at domestic violence sections.

Justice, Crime Prevention and Security (JCPS) cluster

The Justice, Crime Prevention and Security (JCPS) cluster is mandated to achieve Outcome 3 of the Priorities of Government - namely keeping all people within South Africa safe and implementing various governance structures to address the issue of safety, including VAW.[29]

Table 6.2: Structure of the national JCPS cluster

Structure	Chair
JCPS Domestic Violence Task Team, chaired by the Department of Justice and Constitutional Development	DOJ&CD
Inter-sectoral Steering Committee on Sexual Offences	DOJ&CD
Interdepartmental Management Team on Sexual Offences	National Prosecuting Authority (NPA)
Victim Empowerment Management Forum	National Department of Social Development (DSD)

[29] http://www.pmg.org.za/print/report/20120215-department-justice-constitutional-development-implementation-domestic

After noting the lack of a coordinated strategy between JCPS cluster departments to implement and monitor the DVA, the cluster established the JCPS Domestic Violence Task Team to draft, implement and monitor the integrated Domestic Violence Strategy. Thus the DOJ&CD has been mandated by the JCPS to chair this JCPS Domestic Violence Task Team. The team consists of the DOJ&CD, NPA, Legal Aid SA, SAPS, Social Development, Health and the judiciary. Departments of Women, Children and People with Disabilities; COGTA (NHTL), Transport and Housing also play ancillary roles.



South Africa established Sexual Offences Courts to respond to the country's high number of rape cases. *Photo by Trevor Davies*

National Sexual Offences Courts (SOC)

The South African Parliament raised concerns in 2012 about the demise of Sexual Offences Courts (SOC) in South Africa. The country established the first specialist SOC in 1993 in Wynberg, Cape Town, as a pilot project aimed at responding to and preventing the soaring figures of rape cases, as well as acting as an intervention mechanism against secondary victimisation experienced by victims when they consult the criminal justice system. The pilot project proved a success as it maintained a conviction rate of 80% within one year. A decade later, the NPA and the DOJ&CD agreed on a national strategy to roll out specialised SOCs dealing with both adults and children.

By the end of 2005, South Africa had 74 courts, resulting in the finalisation of more cases, improved handling of victims, improved cycle times and improved conviction rates. Lawmakers established SOCs to provide a dignified and speedy court process for women and children. In 2005, the SOCA unit developed a plan for managing the courts. However, that same year the then minister of justice and constitutional development called for a hold on the establishment of all dedicated courts, including SOCs, on the basis that dedicated courts placed too much pressure on resources and forced magistrates to specialise (Shukumisa 2013). Nine SOCs, however, continued to operate in various areas and regional court presidents dedicated a number of courts to prioritising matters related to sexual offences.

In his budget speech delivered in May 2012, Minister of Justice and Constitutional Development Jeff Radebe announced his intention to establish a task team to investigate the viability of re-introducing the SOCs in South Africa. Through the directorship of the DOJ&CD, lawmakers established the Ministerial Advisory Task Team on the Adjudication of Sexual Offences Matters (MATTSO). The MATTSO thus undertook a study that involved empirical investigations, interviews and on-site assessment of a sample of courts that previously operated as blueprint compliant SOCs but currently function as dedicated SOCs. The team identified some of the challenges faced by the SOCs:

- The lack of a specific legal framework to establish these courts;
- The lack of buy-in from other stakeholders due to inadequate consultation;
- The lack of a dedicated budget, which resulted in inadequate resourcing of these courts. The NPA primarily depended on donor funding;

- The lower visibility of these courts in remote areas has been construed as a violation of the Constitution; and
- The lack of a monitoring and evaluation mechanism developed specifically for the management of these courts.

Overall, the report makes a clear case for re-establishing SOCs in South Africa provided these gaps can be addressed. The team also recommended an SOC Model which sets out standard specifications of the operations within the SOCs (DOJ&CD-MATTSO, 2013). The courts will feature a proper screening process to identify cases that fall within the sexual offences category, a special room where victims will testify, a private waiting room for adult witnesses, a private waiting room for child witnesses and victim support services. It will also include a designated court clerk and a court preparation programme for witnesses to prepare for court and to provide debriefing after they have testified.[30]

The team also recommended amending the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007 to provide for an enabling provision which will allow for the re-establishment of Sexual Offences Courts, something the department has already initiated (DOJ&CD-MATTSO, 2013).

The South African Government has already identified 57 regional courts that can operate as SOCs once they have been upgraded and equipped with modern technology. Lawmakers plan to reintroduce 22 of these courts by the end of the 2013/14 financial year, with specially trained officials and equipment to reduce the chance of secondary trauma for victims.[31]

National Prosecuting Authority

Creation of child friendly courts

In showing commitment to the creation of specialised services in sexual offences and child friendly courts, the department of justice committed funds to the progressive procurement of audio-visual court equipment and the establishment of witness testifying rooms. By the end of the year 2011/2012 it supplied the following items:

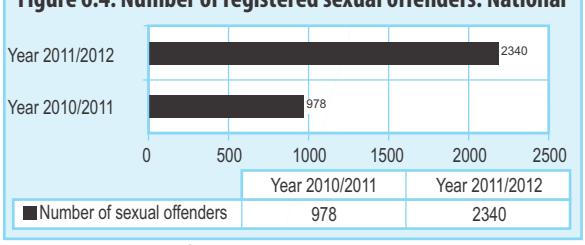
- 335 closed-circuit television cameras;
- 49 one-way mirrors;
- 225 child witness testifying rooms; and
- 195 anatomically correct dolls. The department purchased these dolls to assist child witnesses of sexual offences to testify in court with the demonstrative expression of their personal experiences using the dolls (DOJ & CD annual report 2011-2012).

Every magistrate's court in South Africa has a children's court. This means the country has almost 737 children's courts (FAQ Children's Act 2005). According to the Lower Courts Fact Sheet (2013), Limpopo has 88 magistrate courts, which means it has 88 children's courts.

National Register for Sex Offenders (NRSO)

The National Register for Sex Offenders is a database containing the particulars of those persons convicted of any sexual offence against a child or a person who is mentally disabled or who is alleged to have committed a sexual offence against a child or a person who is mentally disabled in respect of whom a court has made a finding and given a direction that the offender is mentally unfit to stand trial. Its aim is to protect children and the mentally disabled against sexual offenders by establishing and maintaining a record of persons who have been convicted or alleged to have committed sexual offences.[32]

Figure 6.4: Number of registered sexual offenders: National



Source: DOJ & CD annual report 2011-2012.

[30] http://www.southafrica.info/services/court-070813.htm#.UgjpV6CfZc8#ixzz2bph1n9TQ
[31] http://www.southafrica.info/services/court-070813.htm#.UgjpV6CfZc8#ixzz2blNPpG8L
[32] Source: http://www.justice.gov.za/vg/nrso.html

Figure 6.4 clearly shows an increase in the registration of offenders. During 2011/12, the registrar received 39 684 purified names of historical convictions from the SAPS in the very first submission of historical convictions made to the registrar. It is therefore considered to be a huge breakthrough in the registration of this data. Unfortunately, the registrar did not receive data from other sources that had been identified (DOJ & CD annual report 2011-2012).

Access to services in the "I" Stories

Out of the sixteen female survivors who participated in the "I" stories, 15 reported their cases to the police. They received a variety of responses. Police ignored the majority of these cases, leaving the women frustrated when their case stalled in the system. In some instances police lost dockets, in others police released the perpetrator for no apparent reason. In some cases police blamed the victim for the crime or abuse which had befallen her. Despite such negative feedback, it is commendable that a significant number of women reported that police arrested their perpetrators and provided help. Police should also be given credit for the number of times they referred women to the Tshilidzini TCC.

Hospital: Fourteen (88%) of the 16 women who participated in the project went to hospital for treatment or assessment. Seventy-nine percent of the women who visited the hospital after experiencing any form of GBV received counselling. Medical staff treated those who had been injured or raped.

Protection order: Only two women out of the seven who experienced IPV sought a protection order. Courts: Only three (19%) cases went to court. A judge sentenced one of the perpetrators to eight months in prison for attempted rape. Another case ended mysteriously and the courts sent the perpetrator in a third case to prison for another crime.

Conclusion

This chapter has shown that South Africa has implemented progressive and comprehensive laws, policies and support systems to respond to VAW. Some of the regional and international instruments adopted by the country include the CEDAW, SADC Declaration on Gender and Development and the UN Declaration of Basic Principle for victims of Crime and Abuse of Power. South Africa has localised these instruments, giving rise to the DVA, Sexual Offences Act, Employment Equity Act, Service Charter and Minimum Standards for Victims of Crime in South Africa and the National Policy Statement for Victim Empowerment, all of which work towards elimination of GBV in the country. In addition, lawmakers have oriented several government departments towards response and support.

Lawmakers have also created specialised units to respond to VAW. The SAPS, Department of Health, Department of Justice and Community Development and the DSD, among many others, have come together to eliminate GBV and provide support to victims.

However, several setbacks affect the country's progress towards achieving the SADC Protocol target of halving GBV by 2015, despite the presence of these instruments and specialised units. GBV remains a serious problem that is widely underreported. The police and medical data which is available presents just the tip of the iceberg. A gap also exists in data on GBV from the Department of Health, the SAPS and DOJ&CD because it is not disaggregated by age, sex or type of VAW. The data also does not reflect those cases which have been withdrawn. As such, it remains difficult to know to what extent GBV survivors use these services.

Other challenges include a lack of dedication and efficiency on the part of key players in the criminal justice system. This is illustrated in several personal accounts written by survivors who detail negative experiences with the police. Based on some of these accounts, patriarchal attitudes continue to undermine efforts to respond to VAW. These attitudes prevent some women from making use of the legal system, thus creating a vicious cycle.

CHAPTER 7
SUPPORT



Support for the 16 Days, Taking back the night march in Johannesburg. *Photo by Colleen Lowe Morna*

Key facts

- Limpopo province has seven shelters funded by DSD and run by non-profit organisations.
- In 2011/2012 the Limpopo Department of Social Development (LDSD) funded 50 NPOs, most of which are VEP structures.
- During the period under review, LDSD has reduced the amounts disbursed to VEP structures or organisations by 37% and increased funding to shelters by 61%.
- The LDSD has reduced its funding to NPOs by 13% from about R 13.4 million in 2011-12 to R11.7 million in 2012-2013.
- Overall, CBOs reported the highest number of VAW cases seen in the two districts of Vhembe and Mopane, where VAW appears to be rife.
- The number of available structures for VAW support is disproportionate to the number of victims.



My name is Aluwani. I'm 32-years-old and I have two children, Hope (13) and Elisa (11), although I am not legally married. My husband works away from home. One evening, while I was sleeping with the children, I felt like I was dreaming that someone opened the door. I woke up and heard the wind blowing through the window. I got out of the bed to check what was happening and I thought I saw a person. I woke the children up and told them there was a person outside. I called my mother-in-law and told her that there was a person scratching the window. She said I must ask who it is and I told her I had already done that. "Check again," she said. When I checked again the person was gone. I called and told her I couldn't see the person anymore. I switched off the light and went to sleep again with the children.

Hope saw a shadow and she said, "Mum, that person hasn't gone." Then I called my mother-in-law again, she said she was going to come to my house. I switched on the lights again and I sat on the bed. Within five minutes I heard the window breaking. As soon as the person had broken the window he got inside. I then realised there were actually two men and they had hidden their faces with masks. We screamed.

Those men were armed with a knife and a small axe. That knife was put on my neck and they said I was making too much noise. Because I was scared I kept quiet after that. They asked me where my money was so I took out my wallet and gave it to the other guy. There was R110 in the wallet. They took the DVD player and collected our phones. After that they took me outside with the knife still held to my neck. My children were crying but they kept their voices very low. They pleaded with the men: "Please don't kill our mother we are still young." The men said they won't kill me. I told them to take anything and leave me the way I am because my children are young.

When they took me out the other guy stayed in the house. We arrived in an open space outside and he said I must lie down but I refused. He pressed the knife harder and I got more nervous so I lay down and he raped me. When he was done, he dragged me back to the house by holding onto my T-shirt. He gave me to the other guy who took me outside. The man who had just raped me stayed in the house. The man who was outside with me was holding a small axe. He told me to open the door to the room where we cook, which I did. He told me to lie down in there, which I did. He put a condom on and then raped me. By that time my heart was on my children, wondering what was happening to them in the house. When he was done he put me back in the house and they told me to lock the house, which I did and then they ran away.

We then went to see my mother-in-law who accompanied me to Donald Fraser Hospital. When we got there we were told to go to the trauma centre. I was helped by a counsellor. I told her what had happened. She asked me if my husband knows and I said he doesn't know. She said I must call him and explain what happened while I was there. I called, but he dropped the phone before I could finish the story. I just said the word raped and he hung up the phone.

That woman at the trauma centre continued to comfort me and I could see that she was also feeling my pain. She called the police and they arrived immediately to open a case. They asked me questions and I explained everything from the beginning. Unfortunately I couldn't describe the two men who had raped me because of their masks; even the children didn't see them.

The counsellor asked me, "Were they wearing condoms?" Then I said that the first one didn't wear a condom but the second wore a condom. Then she said they must take my blood to test for things that result from incidents like this, like HIV, unexpected pregnancy and other diseases. I tested negative. We went to a doctor who then cleaned me and gave me treatment to prevent HIV because of the rape. The doctor also gave me instructions about when to take the pills. I was told to come back to the trauma centre with my children the following day. The next day

when I went back to the centre, I found a TVEP counsellor there. She talked to me alone and then she talked to the children. I thank TVEP because I couldn't talk to any person about what had happened, but because of attending their workshops I managed to talk to other women and the pastor and now I feel relieved. I started to feel that life was getting better. The father of my children came back the following day and gave me support that I was not expecting. He spent the whole month and when he left he installed burglar bars on the windows and doors.

Aluwani's story is one of of pain and torture followed by a road to recovery. After being raped by two strange men, Aluwani is left in turmoil and feels anger, bitterness, shame and fear. However, she is fortunate and gets help at the trauma centre and also from TVEP, through their counselling and empowering workshops. She also has a supportive family, which helps her overcome the trauma of her attack. This story shows that beyond the occurrence of abuse it is critical for survivors of GBV to get support which facilitates rehabilitation, recovery and empowerment.

This chapter explores the adequacy, accessibility and effectiveness of GBV support services from an institutional and a survivor perspective. The aim is to evaluate support mechanisms in place to assist survivors. This evaluation makes use of data from the prevalence and attitudes survey and administrative data provided by various GBV support organisations.

Since 1994, South Africa has seen a significant shift from the retributive justice system centred on the perpetrator to a more victim-centred restorative system. Support is one of the priority areas identified by the 365 Day National Action Plan of 2007. According to the NAP, support for victims comes in the form of providing safe shelters as well as economic empowerment for the victims and survivors of violence. The plan recommends advocacy and lobbying on the links between GBV and economic development as well as the need for dialogues with relevant stakeholders in challenging the patriarchal system and its oppression of women.

The National Victim Empowerment Programme (NVEP)

The NVEP is coordinated by a number of departments, including Social Development (DSD), Correctional services, Justice and Constitutional Development, SAPS, the National Prosecution Authority (NPA) and the Department of Health. DSD is the lead department for the programme, coordinating within the criminal justice system. The roles of the DSD include:

- To prevent violence against women and children from occurring through a sustained strategy for transformation of attitudes, practices and behaviours;
- To respond to violence in an integrated and coordinated manner by ensuring a comprehensive package of services to affected women and children;
- To monitor prevalence and incidence of gender-based violence against women and children; and
- To ensure follow-up, support and reintegration of victims of GBV.

Each department plays a different role in the provision of services to victims of crime and violence. Services vary from registering and investigating cases to offering medico-legal services and ultimately prosecuting the case through the courts.[33]

Limpopo VEP provincial statistics

Limpopo's Vhembe district reported the highest prevalence of domestic violence in the province. Support workers there recorded 2553 cases in the first quarter of 2012/13 at organi-sations offering GBV services supported by Limpopo DSD. LDSD is currently funding four not-for-profit organisations which run temporary shelters in the province. This number of temporary shelters is still too low compared to the number of funded shelters in other provinces.

[33] http://www.dsd.gov.za/npo/VEP1/index.php?option=com_content&task=view&id=71&Itemid=121

[27] MWAGCD, personal communication.

Table 7.1: Number of NPOs funded by DSD and disbursements 2011-2013: Limpopo Province						
Sector	**Number funded 2011/2012**	**Amounts transferred 2011/2012**	**Number funded 2012/2013**	**Amounts transferred 2012/2013**	**Difference in amounts transferred 2011/2012-2012/2013**	**% increase in funding 2011/2012-2012/2013**
VEP	42	R 10 500 000	43	R 6 582 510	R -3 917 490	-37.3%
Social crime prevention	2	R 1 000 000	4	R 2 080 000	R 1 080 000	108.0%
Shelter	6	R 1 895 600	4	R 3 058 200	R 1 162 600	61.3%
Total	**50**	**R 13 395 600**	**51**	**R 11 720 710**	**R -1 674 890**	**-12.5%**

Source: Limpopo Province - NPO status report and highlights of provincial and district NPO dialogues.[34]

Table 7.1 shows that more NPOs benefit from the LDSD for victim empowerment services. In 2011/2012 the LDSD funded 50 NPOs; VEP structures formed the majority. In 2012/13 the LDSD is funding 51 NPOs. While the LDSD has added funding to one more VEP structure, it has reduced the number of NPOs funded to run temporary shelters. However LDSD has reduced the amounts disbursed to VEP structures or organisations by 37% and increased funding to shelters by 61%. LDSD has more than doubled funding for social crime prevention programs by NPOs. Overall the LDSD has reduced its funding to NPOs by 13% from about R 13.4 million in 2011-12 to R11.7 million in 2012-2013.

The LDSD convened community dialogues to gather input from NPOs about the state of funding from DSD. Recommendations include:

- The NPO Registration Office, which is currently located in Gauteng, should be decentralised to the provinces;
- The Department should develop a uniform funding model;
- The funding of NPOs should include infrastructure needs to improve service delivery and compliance with norms and standards;
- Implement and monitor transformation of NPOs;
- Develop and regulate norms and standards for the establishment of community NPOs;
- The Department of Social Development must have dedicated staff to monitor and support NPOs;
- Review funding criteria to give preference to disadvantaged and emerging NPOs; and
- All NPOs should receive training prior to and post-funding to improve compliance and accountability.[35]



Bathabile Dlamini, Minister of Social Development, at the official opening of the Khuseleka One Stop Centre in Limpopo. *Photo courtesy Google Images*

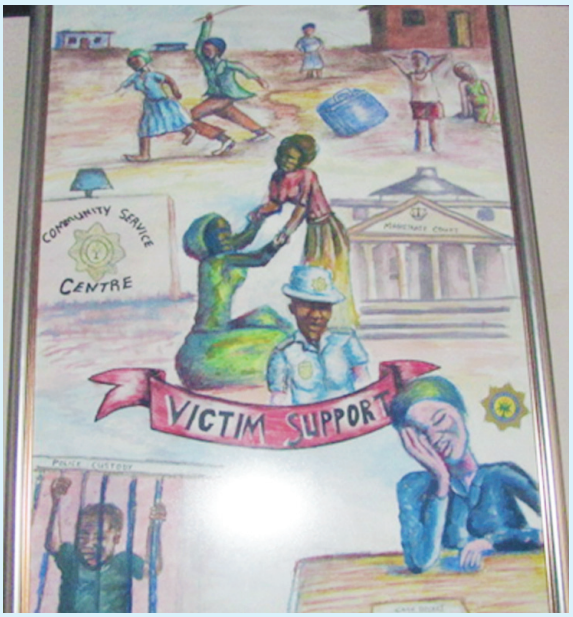
[34] Available at http://www.dsd.gov.za/npo/index2.php?option=com_docman&task=doc_view&gid=112&Itemid=39
[35] Limpopo Province -NPO status report & Highlights of Provincial & Districts NPO dialogues.

Case Study: Polokwane SAPS Victim Support Centre

The Polokwane Victim Empowerment Centre falls within the ambit of South Africa's VEP structure. The centre supports victims by providing counselling and justice through the SAPS.

The Polokwane VEC focuses on response and support to victims of domestic violence as well as prevention of VAW. According to the centre coordinator, the number of domestic violence cases has increased compared to previous years: from about 45 to as many as 70 per month, with more cases recorded during festive seasons.

Women tend to report cases to the centre during national campaigns such as the 16 Days of Activism. The centre provides counselling for survivors and empowers victims to make informed decisions about reporting cases to police. In cases where victims do not want to obtain protection orders, the station officers bring in the perpetrator and provide mediation with the aim of resolving the issue.



A Polokwane VEC poster.

Challenges

Counsellors face challenges getting victims to discuss the abuse they've suffered. This is often exacerbated by women's economic dependency on their partners. Case withdrawals impede justice and also contribute to the recurrence of VAW. Because of this challenge, withdrawals have been banned at police stations and must occur under oath in the courts.

Other challenges include short staffing and lack of financial resources to cover salaries. The centre currently has four staff members who act as auxiliary social workers.

Shelters

In some cases, a victim or survivor may be in need of a safe place to go after they have been abused or victimised. She may not be able to return home if, for example, the perpetrator is a member of the family, a neighbour or member of her community. South Africa has implemented legislation and structures to promote the provision of shelters for victims and survivors of violence.

Shelter services fall under the broader domain of the national government's VEP, a crucial component of South Africa's crime prevention strategy. The DVA stipulates that the SAPS should refer the victim of violence to a shelter or safe house if necessary. Although not specified by the DVA, the Department of Social Development is responsible for facilitating and fast tracking the provision of shelters for abused women, as well as ensuring the availability and accessibility of counselling services for women and children, according to the Minimum Standards on Shelters for Abused Women.[36]

[36] http://www.info.gov.za/view/DownloadFileAction?id=70651

The National Department of Social Development - Minimum Standards on Shelters for Abused Women

The DSD employs a policy called the Minimum Standards on Shelters for Abused Women which serves as a framework outlining a set of guidelines for every shelter that delivers services to victims and survivors of violence. It ensures quality assurance in service delivery and provides standards and information around provision of restorative justice, accountability and empowerment. It also provides a list of minimum standards of services and facilities that every shelter is expected to offer.[37] As previous research has shown, most shelters face serious financial constraints and many operate below these minimum standards because government is not providing sufficient assistance. Non-governmental organisations currently provide an estimated 60% of social welfare services for women and children with minimal help from the government (TLAC 2012).

National Shelter Movement SA (NSM-SA)

Stakeholders established the NSM-SA in 2008 following recommendations from the first Southern African Conference on Sheltering Abused Women and Their Children, held in 2000. Its goal is to strengthen the shelter movement in South Africa by capacitating shelter staff across the country and securing provincial government support. It also aims to be the representative body on sheltering for women and children affected by gender-based violence in South Africa. Through this project the National Shelter Network conducts activities which include building the capacity of provincial shelter managers, establishing provincial forums and hosting quarterly meetings between provincial shelter representatives and the national leadership in order to improve programme delivery, unity and collaboration.[38]

Shelters for abused women in Limpopo

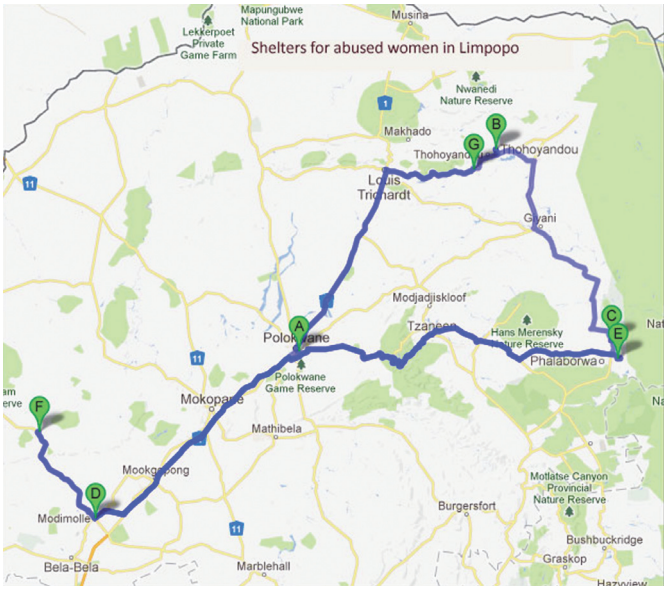
Shelters for abused women can be categorised into three different stages, namely:

First stage is short-term accommodation which usually ranges from three to six months.
Second stage accommodates abused women for a period ranging from six to 18 months, usually after the first stage shelter.
Third stage is more secure and permanent housing for women leaving the first and second stages.

Limpopo province has seven shelters run by NPOs with funding from DSD. Table 7.2 shows the distribution of these shelters.

Table 7.2: Shelters in Limpopo province

	Criteria	Location
A	Child Welfare Shelter for Women and Children	Polokwane
B	Far North Network on Family Violence	Thohoyandou
C	Leka Gape Organisation	Lulekani
D	SAVF - VEP Modimolle	Modimolle
E	South AfricaVroue Federasie	Phalaborwa
F	Tifuxeni Community Counselling centre	Elim (Waterval)
G	Thohoyandu Victim Empowerment	Thohoyandu



[37] Minimum Standards on Shelters for Abused Women http://www.info.gov.za/view/DownloadFileAction?id=70304
[38] http://www.dgmt-community.co.za/organisations/national-shelter-movement-sa

Challenges

- There is a shortage of necessary facilities and human resources in these shelters. Some do not meet the minimum standards stipulated by the DSD as well as the legitimate needs of the women and their children.
- There is a lack of psycho-social services for both the abused women and their children.
- Breakdown of families is common in cases in which the abused woman has male children older than 12. The psychological damage brought about by family separation cannot be overemphasised (TLAC, 2012).
- There is no provision of secondary shelters. As noted earlier, most shelters in South Africa offer first stage accommodation which ranges from three to six month, after which the survivors do not have anywhere else to go, especially if they remain economically dependent on an abusive partner. This forces many women to go back to an abusive partner. There is a dire need to provide long-term safe accommodation for women coming out of shelters. While stakeholders formed the National Shelter Movement of South Africa to assist and hold government accountable to provide access to sustainable human settlement and security for vulnerable families, it has not made much progress in addressing this issue (TLAC 2012).

Organisations providing support services to victims and survivors of GBV in Mopani and Vhembe districts of Limpopo

Various government departments and CSOs respond to GBV in the Vhembe and Mopani districts of Limpopo. For this study we primarily focus on Mopane and Vhembe districts as they characterise GBV hotspots in Limpopo but also have well documented reports on GBV response compared to the other districts. High rates of rape, femicide, domestic violence and ritual killings plague the two districts. Research has shown that GBV remains entrenched in patriarchal cultural structures and harmful religious practices that promote it.



Creating future leaders, Vhembe District Municipality, Limpopo. *Photo by Nomthi Mankazana*

[30] (Direct Communication).
[31] National VAW strategy.

Table 7.3: Organisations responding to GBV in Mopani			
Name of organisation	**Monthly average VAW related cases**	**Programmes or activities implemented to address GBV**	**Challenges**
Non-governmental organisations			
ProGroup Foundation Trust	100	Providing court support, preparation, access to justice and counselling. The organisation has an awareness strategy to create an understanding for a zero tolerance approach to GBV.	• Lack of cooperation and buy-in from DO&JCD. • Lack of buy-in and cooperation from critical stakeholders. • Lack of effective cooperation from other NGOs. • Lack of human and financial resources.
Families South Africa (FAMSA) Limpopo	15	Counselling, play therapy, trauma debriefing, mediation services, community development programmes, victim empowerment, life skills, training, HIV and AIDS (high transmission areas), mentoring emerging CBOs. Awareness campaigns.	• In certain instances, lack of resources or funding for specifically GBV. • Lack of funding leading to high staff turnover.
Community-based organisations			
Maake Community Victim Empowerment	110	Door to door campaigns and crime awareness campaigns. Mobilising women and children and addressing them about GBV.	• Lack of transport to provide after care services and outreach programmes. This makes it difficult to follow-up on cases. • The department of Social Development sometimes takes time to pay and as such the organisation struggles to get food for victims.
Cross the Road and Stay Alive (CRS)	N/A	Child and women abuse services, counselling, prevention of crime and sexual abuse.	• People are afraid to break the silence because most of the abusers are providing for the families' needs. • Lack of transport that makes it is difficult to reach the victims on time. • Lack of finances.
Phapamani Victim Empowerment Centre	10	Trauma counselling and victim support.	• Insufficient funding.
Sekgosese Victim empowerment Centre	20	Awareness campaigns on GBV, rape and crime.	• No transport for effective operation. • Limited capacity to accommodate victims. • Lack of electricity and toilets. • Lack of furniture and different equipment.
Government affiliated			
Middle Water Clinic	1	Awareness campaigns on GBV.	• No commitment of community members and service providers. • Women do not openly report the cases of VAW but present injuries.
Mopani District Office	440	Provide counselling to the victims. Assist them to report cases to the police and/or psychologists. Road-shows, competitions and campaigns.	• Survivors do not report therefore the reports received do not tally to the actual number of incidents. • Lack of funding and support from social and political organisations.

Source: Ecory's report: Assessing organisations and structures that address Gender Based Violence in Vhembe and Mopani Districts, Limpopo; 2012.

Table 7.3 shows that CBOs comprise the majority of GBV organisations in the Mopani district. Yet most cases of VAW (average of 440 per month) have been reported at the Mopani District office. One cross-cutting challenge faced by all organisations is lack of funding, high staff turnover and capacity-building. Survivors also do not make the most of available services.

Table 7.4: Organisations responding to GBV in Vhembe			
Name of organisation	**Monthly average VAW related cases**	**Programmes or activities implemented to address GBV**	**Challenges**
Community-based organisations			
Munna Ndi Nnyii	180	Culture and health, HIV and AIDS, human rights, recognition of OVC.	• Lack of support from traditional leaders. • Poor referral system.
Isibindi Project	60	Personal doll, play therapy, life centre programme, young women empowerment.	• There is minimal adult participation.
Far North Community Care and Development	40	Conducting workshops, awareness through door-to-door campaigns.	• Insufficient funds and transport.
Far North Network on Family Violence	80	Shelter for abused women and children, beading for economic activities, counselling, self-awareness, broadcasting on radio.	• Lack of funds. • Poor staff retention.
Happy Child Care Forum	28	Recreation and educational activities. Door-to-door awareness campaigns.	• Lack of accommodation and funding.
Thohoyandou Victim Empowerment Programme	170	Safe houses, young perpetrator programme (for juvenile sex offenders), help desks (14 situated at rural clinics, one at TVEP Sibasa offices), Zero Tolerance Village Alliance, community mobilisation, research, advocacy and special projects.	• Lack of funding. • High staff turnover. • Limited staff capacity.
Mutale Victims Empowerment	100	Door-to-door campaign, traditional leader committees and churches host debates on GBV.	• Lack of funding, transport and need for big space/shelter.
Vuwani Victim Empowerment	115	Awareness campaigns using promotional materials.	• Insufficient funds. • Lack of accommodation and resources.
Pfukani Victim Empowerment		Door-to-door and awareness campaigns, home visits.	• Insufficient funds. • Lack of knowledge on VAW.
Rotenda Victim Support Organisation	25	Awareness campaigns on VAW, supporting women and children, referrals, counselling and information on criminal justice system.	• Lack of funds. • Community not willing to change beliefs.
Dzata Victim Empowerment	110	Awareness campaigns, workshops, door to door campaigns and educational programme.	• Lack of funding, accommodation for the clients. • Limited staff capacity.
Government departments			
Tshilidzini Thuthuzela Care Centre (TCC)	120	Campaigns (door-to-door and public awareness), distribution of booklets (for those who could not attend staging workshops).	• Conviction rate is still low.
Correctional Service	50	Awareness campaigns and door to door campaigns.	• Financial sustainability. • Need for training and renovation of working space.
Department of Social Development	85	Awareness campaigns and training.	• Lack of resources e.g. for transport, accommodation.
FBOs			
Mighty Grace Christian Fellowship Church	10	Awareness campaigns, bible studies and visit church members' homes.	• Financial constraints for operations.

Source: Ecory's report: Assessing organisations and structures that address Gender Based Violence in Vhembe and Mopani Districts, Limpopo; 2012.

Table 7.4 shows that CBOs in Vhembe District received the highest number of GBV cases. This implies that Vhembe CBOs lead in the provision of GBV services in the district. However, while organisations have been succeeding in raising awareness and prevention, only a few provide shelter and safe houses for abused

women and a handful provide counselling. Far North Network on Family Violence is one of the few providing economic empowerment to the women through beading while Isibindi caters for the needs of abused children by incorporating play therapy.

Organisations in Vhembe - just as in Mopane and the country at large - struggle because of a lack of funding to cover operational costs. However, it is commendable that both districts have been able to foster partnerships between government departments, FBOs and CSOs. As highlighted in Table 7.3 and 7.4, these organisations complement one another as they work toward a common goal. Yet there remain too few organisations to meet the needs of the many victims in the province.

TVEP is one of the few Vhembe district organisations that seek to provide a holistic support system to victims, addressing their psycho-social, legal, safety and health needs. TVEP has also provided some insight about the magnitude of GBV in Vhembe (Thohoyandou Police Precinct). According to the SAPS records, victims reported 321 sexual crimes in 2010/2011 in Thohoyandou. On the other hand, the Thohoyandou Victim Empowerment Centre saw 540 cases of rape and 1440 cases of domestic violence in the same year. It is difficult to get a corresponding figure on domestic violence from SAPS (Ecory's Report, 2012). The following case study elaborates the different support services provided to GBV survivors by TVEP.

Case study: Thohoyandou Victim Empowerment Programme (TVEP)

Background

The Thohoyandou Victim Empowerment Programme (TVEP) has been operational for more than a decade. Its mission is to instigate an attitude of zero tolerance towards all forms of sexual assault, domestic violence, child abuse and HIV and AIDS stigmatisation in Thulamela. TVEP runs two trauma clinics out of Donald Fraser and Tshilidzini Hospitals, with 15 rural help desks. Through these desks TVEP is extending health and psychosocial support services to a myriad of rural villages within Thulamela municipality.

Objectives

TVEP's programme objectives include creating a supportive environment for the victims of sexual assault, domestic violence, child abuse and the HIV and AIDS pandemic; informing the community about their rights and responsibilities pertaining to sexual assault, domestic violence, child abuse and HIV and AIDS; capacitating and rehabilitating victims of sexual assault, domestic violence, child abuse and HIV and AIDS; and ensuring justice is served.



Processes and activities

TVEP provides the support services to promote access to justice. It aims to ensure the provision of a multi-sectoral, one-stop service to victims of sexual assault, child abuse and/or domestic violence, and to encourage a high quality of service delivery. Projects to promote access to justice include:

The Family Violence and Sexual Abuse (FVSA) trauma centres

one-stop centres at regional and district hospitals where survivors can make a statement to the SAPS, receive counselling and be examined and treated all within the same complex. Since October 2002,

every rape survivor meeting the necessary criteria has been provided with post-exposure prophylactics (PEP) and a client-dedicated Survivor Support Officer (SSO) conducts home visits to monitor compliance and side effects.

Consolidated support services
The case management team follows up and monitors all rape cases reported through the trauma centres. The aim of the follow up is to minimise the number of withdrawals (currently more than 50%) and to prepare witnesses for court. Chaperones based at the Sexual Offences and Community Affairs courts provide assistance to victims and feed child witnesses waiting to give evidence.

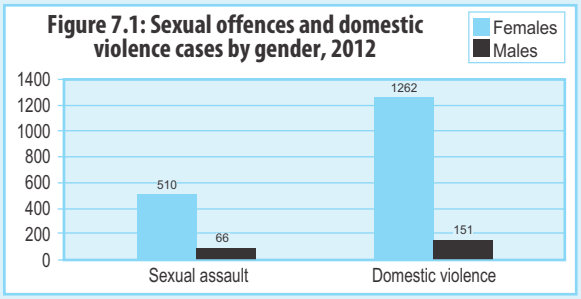


Fiona Nicholson (right) preparing advocacy materials ahead of a Take Back the Night march in Johannesburg. *Photo by Gender Links*

Client transport subsidies
The organisation formed a partnership with local bus companies to enable survivors' access to transport to attend workshops, receive counselling and return to the hospital for follow-up blood tests.

Positive support services
This cluster consolidates all TVEP's HIV-related activities and psycho-social services. The team promotes access to ART and compliance with the regimen, with particular emphasis on children.

Statistics



Source: TVEP

TVEP logged 576 cases of sexual assault in 2012 (510 females). TVEP logged 1413 cases of domestic violence - 1262 female and 151 male victims. Overall, women comprised 89% of DV and sexual assault victims.

Sources of support cited in participant "I" Stories

Family: Out of the 16 "I" Stories participants14 cited their families as the most common source of support. In regards to IPV the victim usually gets support from her family while the perpetrator also gets support from his family. The type of family support received by victims includes encouragement, advice to take action and financial.

Church: Half (8) of the victims received substantial support from their churches and pastors. Support came in the form of prayer, counselling and encouragement.

TVEP/Tshilidzini TCC: More than half of the women accessed help from TVEP or Tshilidzini TCC where they received counselling, went through survivor workshops and received legal advice. Tshilidzini provided most (62%) of the counselling, followed by TVEP (25%).

The Stop Gender Violence Helpline

The SGVH is toll-free and provides anonymous, confidential and accessible counselling, information and referral services to victims, witnesses and perpetrators of gender violence. It is the only national helpline focusing on GBV.

The helpline provides an empowering counselling environment to GBV survivors through an anonymous, confidential and accessible service. The gender line, however, only operates five days a week and is closed on weekends. Help line staff provide referrals and give callers accurate GBV information to facilitate a continuum of care.

NICRO Perpetrators of Intimate Partner Violence Programme

The Perpetrator of Intimate Partner Violence Programme (PIPV) is a domestic violence intervention that focuses on the offender, the victim and the family. The intervention aims to reduce or eliminate the occurrence of domestic violence through exploring the cycle of violence and the effects of violence on the family. The intervention is based on individual counselling and involvement of both the offender and the victim to inform both about how to deal with protection orders and safety plans. The programme also includes anger and conflict management. PIPV consists of 30 sessions conducted over 16 weeks, with each session lasting one to three hours.

Conclusion

South Africa has implemented structures and legislation that provide support systems to the victims and survivors of violence. The national VEP programme has facilitated the establishment and integration of inter-sectoral programmes and policies for the support, protection and empowerment of victims of crime and violence with a special focus on women and children. Police have established VEP centres in police stations across Limpopo province.

Despite these important initiatives, the system is still lagging in meeting the needs of GBV victims. Problems include:

- Maximum utilisation of the services by victims is impeded by the culture of silence and economic dependency of the victims;
- Lack of capacity and commitment among other relevant role players within the VEP;
- Many VEP centres lack the resources to effectively cater for victims;
- The number of available structures is outnumbered by the victims. As highlighted above, there is a shortage of shelters for abused women. Even fewer second and third stage shelters exist, leaving women who leave first stage shelters stranded with nowhere to go. This is exacerbated by the adverse economic conditions faced by many women. Women have few options when they leave shelters and many return to abusive relationships; and
- An assessment of the various organisations responding to GBV in Mopani and Vhembe shows that across the board challenges include lack of sufficient focus on GBV and lack of resources and skills.

CHAPTER 8
PREVENTION



Fiona Nicholson (right) and other particiants at a national event to mark opening of 16 Days event in Johannesburg. *Photo by Colleen Lowe Morna*

Key facts

- Prevention strategies need to address the root causes of GBV as well as create an environment that promotes GBV prevention.
- Political will and commitment is critical to addressing GBV.
- The Sixteen Days of No Violence Against Women and Children is not well known among men and women; Only one in five men and one in ten women heard of the 16 days of activism.
- A lower proportion of women (6%) and men (16%) heard about the 365 Days Campaign.
- Three percent of women and almost a quarter of men (23%) ever participated in a march or event to protest against GBV.
- Most people get their news about GBV campaigns from television.
- Primary interventions for preventing GBV in Limpopo include local door to door campaigns, community dialogues and programmes for engaging men. The interventions are implemented by provincial government and civil society.
- Secondary interventions include training of service providers as part of national departmental programmes.



I (Murendeni) was on my way from school in September 2011 when I met the father of my child. We were no longer in a relationship and he was not providing for his child. He said, "Come take money for the child to buy diapers." When I got closer to him he grabbed my hand and started dragging me to his place. That's when he started beating me, saying that I was a prostitute. "I want to sleep with you by force," he said. I refused, giving the reason that I was no longer in a relationship with him. He said, "That doesn't mean anything. If you can, go get me arrested, I'm not afraid of the police. You'll see, they will not arrest me." I cried as he forced me to have sex with him on the floor without laying down any blankets first.

It wasn't the first time that he was doing this. These incidents happened in the past several times. While we were still in a relationship he would invite me to fetch money for our baby's subsistence. When I got to his home he would say, "Let's have sex first and buy the baby's clothes later." When I suggested that we buy the clothes first and sex later, he would then start beating me. He would tear my clothes off and after sleeping with me he would say he doesn't have money. He would apologise again and we would go on as lovers. I realised that he is abusing me and so I told him I don't want to be with him anymore. He accepted this and boasted about having a wife.

Sometimes he will call threatening to harm me. He would block my way if he finds me walking with another man or he would beat us both. Every time when school ended I would run away before he could find me because he would be waiting for me by the gate. I didn't want to see him anymore because he kept on abusing me.

I decided enough is enough when he forced me to have sex with him last September. I went home crying. I found my mom's elder sister and my grandmother at home and they asked me what had happened. I told them Prince had dragged me to his place and raped me. They asked me if I had bathed and I said no. They took me to the police. I opened a case but he wasn't arrested. When I think of what he did, he hurt me and what hurts the most is that I have reported the case several times but the police never arrested him. He always gets away with it.

I even went to Tshilidzini Trauma Centre but it didn't work out. I was checked by the doctor and he confirmed that I had had sex; he even checked my panties which I left at the centre. They said to me that he would get arrested, but I'm still surprised that nothing has happened to him yet.

After these incidents of being abused I always think about what happened. When I see him I always feel scared, I've even changed my routes. Even when I'm somewhere I get scared that if I see him there, he will beat me because I have reported his abuse to the police. I am also scared to go to school, thinking that he might come after me. I even told my grandmother that I will no longer attend school because I am scared. I am also scared of other men when I think of what has happened to me.

Murendeni's story is one of a young woman who is abused by the father of her child. He uses money as bait. The man refuses to look after their child and takes advantage of Murendeni's low economic status. He physically, sexually and emotionally abuses her. Murendeni opened cases with the police and sought assistance from the trauma centre to no avail.

This is a common story for financially challenged young women who depend on men for money. It illustrates how economic dependence can cost women their freedom. Because of this, economic empowerment of women has been identified as a critical prevention strategy to curb violence against women. This story also notes the failure of the system to detain the perpetrator and bring him to book. This perpetuated recurrent abuse against Murendeni, underscoring the need to strengthen the justice system.

This chapter outlines a compendium of prevention initiatives implemented in the Limpopo province and analyses their effectiveness.

Violence prevention programmes need to be holistic and build on evidence, targeting those at risk (primary prevention) or those who have been victims or offenders in order to reduce re-victimisation or re-offending (secondary prevention).

Primary prevention aims to address GBV before it occurs in order to prevent initial perpetration or victimisation. It includes targeted actions aimed at changing behaviour and attitudes. Primary interventions for GBV seek to address the root causes at individual, relationship, community and societal levels. Interventions can also aim to change risk-producing environments. Strategies include:

- Political will and commitment to address GBV;
- Public awareness programmes;
- Engaging men;
- Using the media;
- Local government initiatives to prevent GBV; and
- Economic empowerment and education.

Secondary prevention happens immediately after the violence has occurred to deal with the short term consequences, for example treatment and counselling. GBV survivors require comprehensive care and support from multiple service providers. This includes health, legal, social services, education, economic and social support. Secondary GBV interventions empower those charged with the responsibility of addressing GBV with the skills to promote prevention and the ability to deal sensitively with the topic. Strategies include training key stakeholders: police; health personnel; traditional leaders; prosecutors and faith-based organisations.

Tertiary prevention focuses on long term interventions after the violence has occurred in order to address lasting consequences - for example, perpetrator-counselling interventions.

This study emphasises documenting primary and secondary prevention initiatives in the different action areas in Limpopo province, as well as evaluating their impact within the South African GBV prevention model.

Figure 8.1: The National GBV Prevention Model

NATIONAL CAMPAIGN:
365 DAYS OF ACTION TO END GBV

PREVENTION

Arenas for action	Communication for social change strategies			Measuring change
	Short Term	Medium Term	Long Term	
Society at large				Behaviour change
Political leadership	Targeted messages	GBV mainstreamed into programmes	GBV a key political issue	
Criminal justice system	Tough laws	Training for personnel	Concerned as much with prevention as response	
Media	Increased media coverage	More sensitive coverage	Prevention agenda	Attitudes
Sport	Individual sportspersons take up cause	Teams take up cause at big events	GBV mainstreamed in sports training	
Community				Awareness
Community	Mobilise community to create safe spaces	Public education & awareness campaigns	Zero tolerance for GBV in communities	
Traditional leadership	Training	Harmful practices	GBV a key local issue	
Schools	Increase security in schools	Challenging gender stereotypes	Behaviour change	
Religion	Spread the word	Review own practices	Lead the campaign	Information
Individual/family				
Abusive men	Stop violence	Join the campaign	Lead the campaign	
Abused woman or child	Shelter and temporary life skills	Secondary housing	Economic empowerment	

SUPPORT

RESPONSE

Figure 8.1[33] identifies a number of "arenas" in which GBV is reinforced or can be challenged. This includes the individual, community, and society at large. It occurs within the context of the prevention, response

[33] Adapted from UNICEF et al. Violence prevention model and action plan, www.unicef.org/southafrica/SAF_resources_violenceprevmodel.pdf

and support ecological model used by the IDMT. The model also recognises that interventions can be short, medium or long term and that one may be necessary for the other. It further recognises that the ultimate objective of any intervention is to progress from information to awareness to changes in attitude to behaviour change.

It recommends actions to be taken in the short, medium and long term. Key elements include:

- *An overarching national framework* or campaign that provides an enabling environment for initiatives in all spheres and at all levels of society. This builds on the 365 Days of Action to End Gender Violence, with the annual 16 Days of Activism campaign as a way of heightening awareness as well as enhancing accountability for targets.
- *Understanding the relationship between prevention, response and support*. While the focus is on primary prevention, the model emphasises that good response and support mechanisms should also contribute to prevention. For example, tough laws and their implementation should serve as a deterrent to GBV. Shelters should not only provide temporary refuge but empower women to leave abusive relationships, thus preventing secondary victimisation. Working in unison, prevention, response and support strategies can both reduce GBV and ensure redress for those affected.
- *Stepping up targeted primary prevention interventions at three key levels:* In the home (women, men, children and the family); the community (traditional leaders, religion, schools and sports); and the broader society (the criminal justice system, media and political leadership). Again, if well designed, these initiatives should form a continuum. An initiative to empower abused women should also seek to change the way that their families, communities and society address GBV.
- *Identifying approaches and strategies that work* based on communication for social change theories and using these in the design of future interventions.
- *Developing more effective monitoring and evaluation tools,* bearing in mind that up to now most of the data available concerns outputs rather than outcomes. Ultimately, prevention campaigns must be able to demonstrate that their impact moves beyond information and awareness to create knowledge, wisdom and behaviour change. This in turn should lead to a quantifiable reduction in GBV.

Areas for action

The ecological model locates key arenas for action:

- ***Individual:*** The first level identifies biological and personal history factors that increase the likelihood of becoming a victim or perpetrator of violence. These include age, education, income, substance use, or history of abuse.
- ***Relationship/family:*** The second level includes factors that increase risk because of relationships with peers, intimate partners and family members. A person's closest social circle peers, partners and family members influences their behaviour and contribute to their range of experience.
- ***Community:*** The third level explores the settings, such as schools, workplaces, and neighbourhoods, in which social relationships occur and seeks to identify the characteristics of these settings associated with becoming victims or perpetrators of violence.
- ***Societal:*** The fourth level looks at the broad societal factors that help create a climate in which violence is encouraged or inhibited. These factors include social and cultural norms. Other societal factors include health, economic, educational and social policies that help to maintain economic or social inequalities between groups in society. These so-called contact crimes usually occur between people who know each other (e.g. friends, acquaintances and relatives). Yet the courts, police and society at large still often find it difficult to understand how a woman can be raped by a person she knows.

An ecological approach to GBV argues that no one factor alone "causes" violence but rather that a number of factors combine to raise the likelihood that a particular man in a particular setting may act violently toward a woman.

Political will and commitment to address GBV

For a violence prevention strategy to be successful it has to be unified, coordinated, scientifically-informed,

well-resourced and directed across all clusters of society, government departments and civil society. The most effective way to fight violence against women is a clear demonstration of political commitment by states, backed by action and resources.

National Public awareness campaigns: 16 days of Activism campaign

Level of action: individual and community

Each year, stakeholders hold several events to raise awareness about GBV and mobilise key stakeholders as well as the public to take action against violence during the 16 Days of Activism.

Key dates include:

- 25 November: International Day of No Violence against Women
- 1 December: World AIDS Day
- 3 December: International Day for the Disabled
- 10 December: Human Rights Day

Every year, government, civil-society organisations and the business sector work together to broaden the impact of the campaign. By supporting this campaign, thousands of South Africans have also helped to increase awareness of abuse and build support for victims and survivors of abuse.

National Symbols and messages





Each year since the advent of democracy in 1994, the government, spurred on by NGO efforts, has increasingly taken ownership of the campaign. The government symbol for the campaign is the beating drums, to which it later added the strap line "Act against abuse." In 2007, government added to this the "Don't look away" concept illustrated in the graphic. Government refers to the campaign as the "16 Days of Activism Against Women and Child Abuse" and promotes use of the white ribbon, which is the international symbol of protest against gender violence.



NGOs have created their own variants to this theme and messaging. In 2004, NGOs chose to call the campaign "16 Days of Peace" with the strap line "Imagine a world free of gender violence, HIV and AIDS." In 2005, some chose the slogan, "Peace begins at home" arguing that this is a simple and positive message that is easy to translate into many languages.

One point of departure has been in the promotion of the red and white as opposed to just the white ribbon. The red ribbon is the symbol for HIV and AIDS. Nisaa Institute for Women and Development pioneered the red and white ribbon campaign in South Africa as a way of raising awareness on the link between gender violence and HIV and AIDS.

Since 2009, the Minister of Women, Children and People with Disabilities has championed the campaign and activities during this period have been coordinated by the Department of Women, Children and People with Disabilities (DWCPD). Departments, provinces and civil society organisations will use this framework as a tool to assist in determining focus areas.

Stakeholders created the international theme "From Peace in the Home to Peace in the World: Let's Challenge Militarism and End Violence Against Women" in 2012.

The vision of the government and recommendations and findings of the 10 Year Social Impact Assessment

largely informed the objectives for the 2012 campaign, which called for:

- Government to strengthen partnerships and collaboration with NGOs and Community Based Organizations (CBOs) - including those that target and involve men and boys for prevention and rehabilitation - faith-based organisations, traditional leadership and healers as well as the business sector, in crafting a coordination plan;
- The rallying of partners to strengthen the pillars for a more effective and rigorous implementation of the 365 Days National Action Plan - especially the prevention pillar in as far as it concerns root causes;
- Encouraging community involvement in initiatives to combat crimes against women and children;
- Communicating government's substantive programmes and priority actions to deal with the problem of women and child abuse; and
- Announcing the National Council Against GBV.

Awareness of and participation in national campaigns

Researchers asked women and men participating in the Limpopo survey about their knowledge and participation in GBV campaigns.

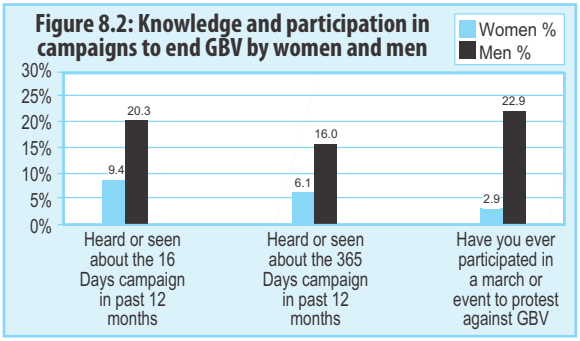


Figure 8.2 shows that women and men in Limpopo province are relatively unaware of GBV campaigns. One in five men and one in 10 women heard of the 16 Days of Activism. A lower proportion of women (6%) and men (16%) knew of the 365 Days Campaign. Three percent of women and almost a quarter of men (23%) had participated in a march or event to protest against VAW. General awareness is low overall, although these figures show that men are more aware of campaigns than women. These findings indicate unequal access to campaign information. Men in the province seem to have more access to information about campaigns and greater ability to participate in GBV events. These findings point to a need for greater outreach efforts, especially geared toward women.

Source of information of events or GBV awareness campaigns

The survey asked participants further questions about any campaign information they had seen or heard about.

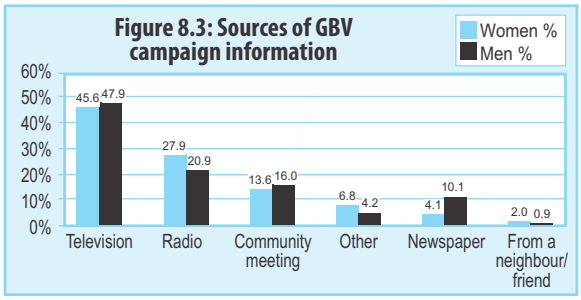


Figure 8.3 show that the majority of women (46%) and men (48%) heard about the GBV campaigns through television. Twenty eight percent of women and 21% of men heard of the campaigns through the radio and 16% percent of men and 14% of women heard about campaigns through community meetings.

While television is the most common medium used to access information for both women and men, greater proportions of women access information from radio and from friends. In contrast, greater proportions of men access information from community meetings and newspapers.

This finding shows that stakeholders should publicise GBV campaigns on television and radio to assume maximum outreach impact in Limpopo province. However, there is also a need to accelerate efforts to disseminate this information at community meetings and in print media.

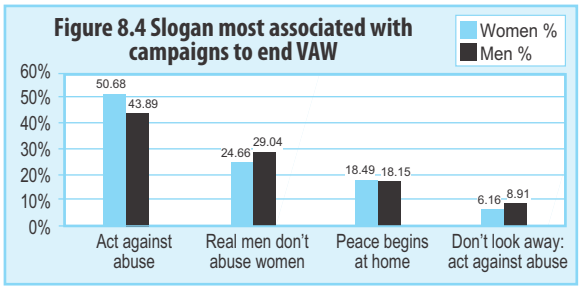


Figure 8.4 illustrates that "Act against abuse" is the most well-known slogan, with 51% of women and 44% of men linking it to GBV campaigns. The next slogan most associated with GBV campaigns is "Real men don't abuse women" (25% women and 29% men), followed by "Peace begins at home" (both 18%) and "Don't look away" (6% women and 9% men).

Case study: GL Centres of Excellence Program - working with councils to develop local government GBV action plans and strategic communications training

Area of action: Community

The UN Secretary General's report on GBV calls on states to build and sustain strong multi-sectoral strategies, coordinated nationally and locally. The GL Centres of Excellence (COE) process arose from the realisation that the only way to have a real impact at the local level is to work at council level. While policies and strategies at national level remain important, these exist as so many words if they do not get translated into action on the ground. Similarly, it has become clear that the lofty targets of the SADC Protocol on Gender and Development need to be localised.

GL, in partnership with the SALGA, is working with councils across Limpopo province that have elected to join the Centres of Excellence for Gender Mainstreaming in Local Government that devise and implement local level action plans for attaining the SADC Protocol targets.



Irish Aid and GL reference group gender mainstreaming training in a Limpopo province local council. *Photo by Ntombi Mbadlanyana*

The COE concept seeks to identify key councils across the country and work to get gender on their agenda. The approach also seeks to develop synergy in GL programme work by focusing various projects from GL's SADC Gender Protocol, governance, media and justice programmes in specific localities.

Key principles include getting buy-in at decision-making level; conducting a situation analysis that is council-specific and will help to address the needs of that council; and conducting council-specific gender and action plan workshops that localise national and district gender policies and action plans. Other activities include community mobilisation aimed to familiarise communities with the provisions of the SADC Protocol on Gender and Development and empower them to hold their councils accountable.

GL builds the capacity of council officials and political leaders through on-the-job training and assisting councils and communities to apply these new skills through running major campaigns, e.g. 365 Days to End Gender Violence and the 50/50 Campaign.

Case Study: South African Local Government Association (SALGA) Limpopo - capacity building

SALGA Limpopo is actively involved in campaigns which seek to address GBV in five districts located within Limpopo: Vhembe, Waterberg, Capricorn, Sekhukhune and Mopani.



Burgersdorp Village residents take part in a GBV community dialogue in 2012.
Photo by Ntombi Mbadlanyana

SALGA Limpopo's overarching mandate is to build the capacity of the municipalities and ensure monitoring and implementation of the GBV Action Plans. From 2008 to 2009, SALGA, in collaboration with GL, hosted the GBV planning workshops, which saw several councils develop GBV action plans.

SALGA Limpopo, with support from various political champions located in the councils, has been part of the Sugar Daddy Campaign, an advocacy campaign that aims to highlight the growing phenomena of transactional sex between older men and younger women. This trend has been noticed in areas or localities with high levels of GBV and unemployment.

Achievements

SALGA has facilitated various stakeholder engagements and committees formed between the Department of the Premier and the Limpopo Department of Health.

SALGA has been instrumental in establishing the District Local Aids Councils, part of a national mandate for each province. The activities of the DAC of the Limpopo province feed into the Provincial AIDS Council (PAC) which ultimately feed into the South African National AIDS Council (SANAC). Stakeholders established this structure to ensure a multi-sectoral approach with regards to HIV and AIDS.

SALGA will continue to oversee these council processes as well as ensure council implementation of GBV Plans.

Challenges

Several challenges have impeded progress in the implementation of the plans:

- Lack of coordination between various stakeholders, as well as lack of accountability from managers and those responsible for implementing plans. It appears the senior managers - and chief custodians of the plans - have not yet prioritised the programme. Quite often managers have exhibited ignorance on issues of gender mainstreaming and do not understand the basic concepts; therefore it becomes difficult for them to understand their role in implementation.
- Challenges around budget allocation. To date there is no explicit budget allocated towards the rolling out of the plans within the municipalities. Very often councils only address and cost projects that address GBV if they link to a commemorative day or fall during the 16 Days of Activism.
- A lack of current statistics and clear indicators from SAPS makes it difficult to monitor cases of VAW. The number of cases that go unreported is also an area of concern.

Community mobilisation

If properly implemented, community mobilisation can be a powerful tool in addressing VAW. It involves engaging community members and incorporating their ideas in a strategy to combat VAW. As such, it can be viewed as a process which initiates a dialogue among members of the community to determine how to look at issues in the context of that community. It also provides an outlet for community members to participate in decisions that affect their lives (Tedro et al 2011).

Beyond promoting social dialogue, community mobilisation provides a platform for social change by empowering community members and leaders to take charge of their own health through engagement in a collective process. Through community mobilisation, women can be empowered to break the culture of silence and take action against VAW. Community engagement also raises awareness among men and challenges behaviours that perpetuate women subordination and condone violence against women.

Case Study: LDOH work to address VAW

Working in partnership with Irish Aid and other partner organisations, the Limpopo Department of Health (LDOH) undertook projects to address GBV in the province. It established a district reference group constituting various NGOs in Mopani and Vhembe. It aimed to further identify challenges in the respective areas and raise awareness on VAW. The reference groups provided feedback to other stakeholders about progress made in the communities.

Activities in 2011-2012

Door-to-door campaigns identified those villages that exhibited high incidence rates of DV. Researchers conducted studies in these villages and asked women about their experiences of VAW. They found high rates of GBV and noted that a culture of silence impeded government efforts to address it. Most women did not want to open up about VAW.

LDOH conducted six workshops in Mopani to raise awareness about femicide. It also educated citizens about ritual murders, which are common in the region. The teams conducted similar activities in Vhembe District, including an additional project - the Zero Tolerance Village Alliance Project - conducted in collaboration with TVEP and GL.



Maruleng village residents take part in an Irish Aid GBV community dialogue about witchcraft and ritual murder in 2012.
Photo by Ntombi Mbadlanyana

Achievements

- The establishment of provincial government bodies and reference groups which have assisted in the identification of challenges, coordination of campaigns, providing feedback and gender mainstreaming within communities.
- The door-to-door campaigns proved a success, especially the involvement of youth. This campaign gave them further insight into what is happening on the ground.

According to the LDOH representative, the partnership between the LDOH and Irish Aid proved a success: "Our department made a breakthrough because of its partnership with Irish Aid and the Office of the Premier is appreciating our work addressing GBV and witchcraft."

Assessment of the organisations engaged in primary prevention of GBV in Mopani and Vhembe districts of Limpopo

After assessing 46 organisations (listed in Chapter 7) that engage in the area of GBV in Limpopo, only four stood out in Ecory's study as potentially promising in addressing GBV prevention in the province. The study assessed 15 CBOs, 12 government institutions, six NGOs, five traditional or religious institutions and eight VEP structures. TVEP in Vhembe, the Thuthuzela Care Centre in Tshilidzini, FAMSA Vhembe and ProGroup Foundation Trust in Mopani stood out as the most promising organisations. These four organisations showed a clear understanding of the root causes of GBV in their communities and they had implemented constructive efforts to address it. Using an assessment framework based on seven qualities, the research team further explored the GBV prevention activities undertaken by these organisations. The seven qualities that characterise best practice in addressing GBV are outlined in the table below.

Table 8.1: Best practice characteristics for addressing GBV

Criteria	Tshilidzini TCC	ProGroup	FAMSA	TVEP
Addressing the root cause of GBV	Focuses more on treatment of GBV victims although at times when resources are available they do engage in awareness raising activities.	Addresses lack of information about women's rights and basic human rights. They conduct awareness campaigns where staff hand out pamphlets and advise women of their rights when they go for protection orders.	Provides parental skills, family preservation, marriage preparation, conflict resolution and trauma counselling programmes to the community.	Since its inception in 1997, it co-opted a range of stakeholders as trustees of the organisation. These included representatives from SAPS, the departments of health and social development, traditional leaders and healers, and faith-based organisations. Each tackle the root causes of GBV relevant to their area of work.
Empowering excluded sectors of society	It is reaching out to excluded sectors of society through its campaigns.	Does not empower excluded members of the community.	Accepts all family types, including same-sex families, but does not have specific programmes targeting excluded persons.	It works with sex workers and their organisations like Sisonke. It also collaborates with Sonke Gender Justice Network and SWEAT. Each victim supported by TVEP is linked to a victim advocate who prepares them for court hearings and supports Post Exposure Prophylaxis (PEP) adherence of victims.[34] Advocates also support children in child abuse cases. TVEP is currently expanding its support for abused children or children who witness domestic violence.
Promoting community ownership and private-partner partnerships	Promotes community ownership by encouraging communities to be TCC ambassadors.		Promotes community ownership by involving the community in its violence awareness programmes in schools. Educators trained to report child abuse.	Peer educators are chosen by the community before being tested and trained by TVEP. The helpdesk is operated by persons who form part of the community and nominated by the community. The oath taken by local chiefs to denounce and stop GBV in their communities is a profound indication of community ownership.

Criteria	Tshilidzini TCC	ProGroup	FAMSA	TVEP
Challenging negative conceptions of masculinity in a culturally sensitive manner	Encourages men to join men's forums to learn more about preventing GBV.	Raise public awareness of the Constitution, which clearly stipulates that gender equality must be practised and enforced.	FAMSA reported that its programmes challenge negative conceptions but it did not specify how.	Works closely with community leaders and seeks advice about traditional response to various violent behaviours to ensure that it is enforced. Where there appears to be conflict, it promotes adherence to the constitutional law.
Adapting activities to the culture and traditions of the area	Tshilidzini did not specify how it adapted its activities to the culture and traditions of the community.	ProGroup Trust does not adapt its activities specifically to the culture and traditions of the area.	FAMSA insists on interactive sessions in which participants learn from each other and compare traditions regarding specific situations.	It seeks advice and support from traditional leaders at every step. The Zero Tolerance Village Alliance programme encourages local chiefs to be the first to take an oath against abuse in front of his people, followed by prominent leaders and all the males. Women also take a public oath not to accept or keep quiet about abuse.
Promoting holistic responses in "one-stop" continuum of care arrangement where various services for the victims are provided in one place	The TCC has all service providers available, accessible and ready to serve the victims.	Provides counselling, information, medical assistance if needed as well as access to PEP at its community centre in Tzaneen. It also conducts court support and preparation, assistance with obtaining a protection order and maintenance order.	FAMSA provides limited information to victims and the community at large.	TVEP provides a one-stop set of services at its two trauma centres with temporary shelters, 14 rural helpdesks, Zero Tolerance Village Alliance, community mobilisation around prevention, stigma mitigation, ARV adherence, among many others.
Enabling civil society groups to hold policy makers accountable	Tshilidzini is a member of the District VEP forum, which fights for government accountability.	ProGroup holds government accountable at a local and regional level by attending stakeholder meetings and assisting organisations such as the NGO Treatment Action Campaign (TAC) to ensure compliance with the victim charter and the Constitution.		TVEP encourages people to stand up for themselves, resist abuse and claim their rights. TVEP undertakes systematic monitoring and follow-up of all rape and domestic violence cases brought to its attention. To date, TVEP has monitored more than 9000 cases of GBV since it started operations in the past 12 years.
Promoting the establishment of a systematic approach to data collection	Tshilidzini does not collect statistics.	ProGroup has been collecting some client data since 2010.	FAMSA is not yet collecting systematic data on GBV.	TVEP has a large amount of data in its intake forms that it has been collecting systematically for more than 15 years. The Institute for Security Studies is assisting TVEP in preparing the data for analysis.

Source: Adapted from the Ecory's report: Assessing organisations and structures that address Gender Based Violence in Vhembe and Mopani Districts, Limpopo, 2012.

[34] The TVEP support to rape victims has increased PEP adherence in Thohoyandou to close to 80% compared to 30% in the rest of the country.

Table 8.1 indicates that of the four organisations assessed, TVEP excels in terms of involving the community in the processes of GBV prevention. It is also better at data collection. TVEP adopts a rights-based approach and insists on holding government services and communities accountable for implementing the law protecting women from GBV. The other three continue to do their part though at a minimal level of operation. Basing on these findings, other organisations in the province need to be further capacitated and the TVEP model of operation must be replicated in other areas. Government should also provide the needed resources to support other community-based CSOs that have the vision but seem to lack the capacity.

Engaging traditional leaders and prosecutors

Traditional leaders wield influence and command much respect within their communities. Traditional leaders as custodians of culture occupy a strong position to work with their communities to address the harmful cultural practices that trigger and perpetuate VAW. In South Africa they preside over customary law courts and reach communities through imbizos/lekgotlas, or community dialogues. South Africa's National House of Traditional Leaders has members in all the nine provinces. It is the officially recognised organisation of traditional leaders in the country.

The NHTL was inaugurated on 18 April 1997. It was originally called the National Council of Traditional Leaders (NCTL) but the name changed in 1998, to the National House of Traditional Leaders. In his inaugural address to the NHTL, former South African President, Mr Nelson Mandela, said: "When the new constitution was drafted, there were concerns that it did not define in sufficient detail the status and role of Traditional Leaders and that it did not, unlike the interim constitution, oblige government to set up this council." The NHTL is an organisation that stands for transformation and equality amongst everyone. Ongoing capacity building needs to be conducted with Traditional Leaders so that they can deal with SGBV cases on merit and not based on their personal values and attitude. Once confident and skilled enough, Traditional Leaders may be able to cascade the knowledge. Each province, with the exception of the Western Cape, has a Provincial House of Traditional Leaders with a clear, province-specific vision and mission that promotes autonomy, transparency and institutions that are gender sensitive. NHTL unifies the Traditional Leadership and guides it on protecting diverse cultural practices.

Case Study - Population Council Dialoguing and capacity building of traditional leaders

Background

The Population Council, in partnership with the Ubuntu Institute, embarked on a programme to engage Traditional Leaders in three South African provinces (North West, KwaZulu-Natal and Limpopo to address sexual and gender-based violence (SGBV) in rural communities. The overarching goals of the programme were to strengthen linkages between the Population Council and traditional communities, generate and share strategic information on SGBV, strengthen prevention and response to child sexual assault, engage new partners to address prevention of and access to SGBV services, and expand access to comprehensive post-rape services by working with Traditional Leadership structures.

In order to strengthen community-based initiatives and to understand the potential role of traditional leaders in the prevention of SGBV, a series of workshops was held in three provinces. Workshops provided information on the state of SGBV in individual provinces, on the need for a multisectoral approach to SGBV, and the potential for strong advocacy from traditional leaders on prevention and management of SGBV. From these workshops, researchers highlighted a number of important lessons learned and recommendations for further action.

Findings

The key findings from the programme by the Population Council include that

- Traditional Leaders are still largely uninformed about the drivers of SGBV in South Africa and need further capacity building.
- Traditional Leaders suggested should have stronger ties between themselves and the court systems/magistrates for better referral and so that cases are managed more effectively.
- Traditional Leaders need to work closely with local government officials and other government agencies to support the empowerment of women in their communities, engagement of men, and to sensitise their communities about SGBV.
- Through social mobilisation campaigns, Traditional Leaders can play a vital role in strengthening prevention and responses to SGBV as they reach thousands of people in their communities at a grassroots level. They are willing to support such campaigns.
- Traditional Leaders need protocols and guidance documents which they regard as a critical component for effective and comprehensive programming.
- Traditional Leaders need to be better linked to the justice system and to the South Africa Police Service (SAPS) to be able to more effectively deal with perpetrators.
- Traditional Courts are an important platform for addressing and adjudicating gender-based violence cases in rural communities and need to be revived or strengthened where they already exist.

Adapted from http://www.popcouncil.org/pdfs/2010RH_TradLeadersFinalReport.pdf

While the findings of research show limited capacity of traditional leaders in addressing GBV, some of leaders hve shown leadership in the fight against the scourge. The following case study is one of a female leader Hosi Tinyiko Nwa'mitwa who has championed programmes to address sexual and reproductive health issues including GBV.

Case study: Traditional leadership addressing GBV, Sexual and Reproductive Health and HIV in Nwa'mitwa, Limpopo



Photo http://nwamitwa.org.za/?attachment_id=192

Hosi Tinyiko Nwa'mitwa II was appointed as heiress to the throne in 2002. However this appointment was contested since according to custom it was taboo for a female to rule a clan. After contesting in court for six years eventually Hosi Nwamitwa was inaugurated in 2008 as one of the very few women among South Africa's approximately 750 traditional leaders. She rules Nwa'mitwa in Tzaneen which is in South Africa's Limpopo Province. Currently Hosi Nwa'mitwa II is Chairperson of the Valoyi Trust and a Member of the South African Parliament. The Valoyi Traditional Authority was established in 2004 with the aim of improving the social and economic well-being of the Nwa'mitwa (Valoyi) community. Since Hosi Nwa'mitwa II's inauguration she has been implementing programmes that seek to address HIV, gender based violence (GBV) and Sexual and Reproductive Health (SRH) in her community. Her goal is to promote youth and women's rights through implementation of a job and life skills training programme called the *Fit for Life, Fit for Work* programme. *Fit for Life, Fit for Work* is a six week work preparedness and sexual and reproductive health and rights (SRHR) programme offered to vulnerable post matriculants (those who have completed Grade 12) between the ages of 18 and 30 years.

The SRH component of the course is aimed at equipping learners with information to prevent HIV, STIs and GBV. It aims to train 120 young men (30%) and (70%) women annually. In 2011-2012, 125 were trained through the six weeks life coping skills (SRH, GBV, HIV) and 102 in basic computer literacy phase one. In phase two through work related skills 78 got trained on Early Childhood development. Fifteen got their driving licenses skills. Out of 117 graduates 48% young people got paid jobs, working in offices, shops, lodges; filling stations and 52% got temporary jobs.[35]

The programme has been strengthened through the active participation and leadership of community members and the beneficiaries themselves. Community members are currently building the community centre where the *Fit for Life, Fit for Work* programme will be housed. Seven groups are engaged in various projects in different villages such as sewing, embroidering, brick making catering and decoration, car wash etc. The programme has been successful in affording youth, who are selected for the programme based on vulnerability to HIV, to get employment and to start small businesses so as to support themselves, their families and other dependants. Through raising awareness and economically empowering her community members, Hosi Nwa'mitwa II has shown that traditional leaders have a crucial role to play in the fight against GBV and HIV.[36]

Adapted from the case study 'Traditional leadership addressing GBV, Sexual and Reproductive Health and HIV in Nwa'mitwa by SAfAIDS, 2011

[35] http://nwamitwa.org.za/?page_id=93
[36] http://www.k4health.org/sites/default/files/traditional%20leadership%20addressing.pdf

Engaging men, exploring masculinities

Programmes addressing masculinities often seek to explore what "makes a man." The overarching idea is to educate boys from an early age that violence is wrong and that the prevailing definition of masculinity in any society is not the only alternative.

Boys also learn that even though they may be physically different, girls are entitled to the same rights and opportunities as men. Gender roles and expectations condone male VAW, grant young and adult men the power to initiate and dictate the terms of sex and make it very hard for women and girls to protect themselves from violence. Strategies to address both HIV and GBV must include scaled up efforts to address gender inequalities. To be effective, such strategies must engage men and boys and bring about significant changes in their attitudes and practices towards sex, women, their own health and their role in caring for and supporting children. Leaders should also facilitate and support necessary changes in community norms that influence VAW-related behaviours of boys and young men.



GL collected two administrative case studies of programmes for engaging men in Limpopo province. One is the One Man campaign, a national programme championed by Sonke Gender Justice Network that has decentralised operations in the province. The other is from Munna Ndi Nyi, a community-based organisation operating in Vhembe district. Though operating at different levels, both Sonke and Munna Ndi Nyi work with men and boys to eradicate GBV and achieve gender equality.

Access to Justice Project

Sonke Gender Justice Network
HIV/AIDS, Gender Equality, Human Rights

The *Access to Justice project*, is a joint initiative by TVEP and Sonke Gender Justice Network which seeks to create a supportive and enabling environment for survivors of sexual assault, domestic violence and child abuse, and for people living with HIV and AIDS. The initiative specifically aims to engage men and boys effectively in preventing gender-based violence and HIV in Limpopo. In its quest to involve more men and boys to prevent sexual violence, the Access to Justice Project is rolling out Sonke's flagship One Man Can (OMC) campaign and the national Brothers for Life campaign.

The OMC campaign encourages men to work together with other men and with women to take action to build a movement, to demand justice, to claim their rights and to change the world. The Brothers for Life complements OMC by creating a strong focus on HIV and the role that men play can play in prevention of the disease and addressing the social and health consequences of HIV and AIDS. Targeting older men, Brothers for Life emphasises the risks associated with having multiple concurrent partnerships, men's limited involvement in parenting, lack of knowledge of HIV status, low levels of testing and disclosure, and delayed and inadequate health seeking behaviour.

While a large part of the project focuses on supporting TVEP and strengthening their capacity and resources, the Access to Justice Project also includes public and community awareness raising campaigns, men's dialogues, workshops on violence with men and boys, and a range of consultative meetings with government.

Case study: The One Man Can campaign

Background

Sonke launched its One Man Can (OMC) campaign on 25 November 2006 to mark the beginning of the 16 Days of Activism to End Violence Against Women. Formative research carried out for the campaign indicates that a growing number of men and boys worry about escalating levels of domestic and sexual violence and say they would like to do more to address it.



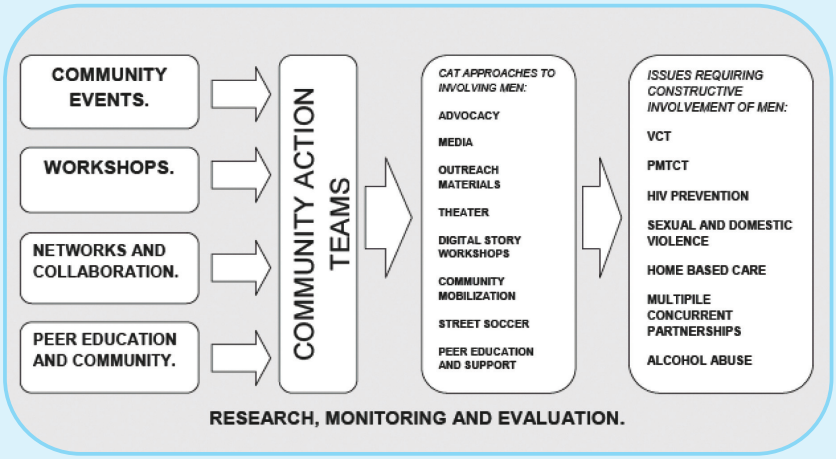
Photo courtesy of Sonke Gender Justice

Programme aim

The OMC campaign aims to support men to advocate for gender equality, including taking active stands against domestic and sexual violence and to promote and sustain change in their personal lives to protect themselves and their partners from HIV and AIDS. This includes changing the gender norms driving the rapid spread of HIV.

Programme description

The campaign provides carefully researched information and tools that men and boys can use to act on their conviction that men have a critical role to play in addressing gender-based violence and HIV and AIDS. Sonke has developed and successfully implemented a unique model, called the One Man Can Community Mobilisation model, which focuses on the role of men and boys in gender transformation. The model is illustrated below:



The One Man Can Campaign has now been implemented in all of South Africa's nine provinces.

Capacity building

Sonke is building the capacity of partner organisations and training them on how to engage men in addressing GBV. Using the OMC manual, Sonke facilitates three day workshops and community dialogues with relevant stakeholders. In Polokwane, Sonke works with the National Institute for Crime Prevention and Re-integration of Offenders (NICRO) and its partner organisations, capacitating them to employ the OMC model in their work with sexual offenders. In Tzaneen, Sonke has partnered with some of the local radio stations and trains the radio staff members on the OMC and media advocacy. Sonke has also held community dialogues and OMC workshops with TCC staff members.

Assessment of the national One Man Can campaign

While Sonke has not conducted a provincial impact assessment of the programme, an independent impact evaluation of campaign based on self-reporting indicated significant changes in the short-term behaviour of participants in the weeks following One Man Can activities (Report on the Impact of Sonke, 2009). The Impact evaluation research conducted to determine the effectiveness of the Sonke Gender Justice Network's One Man Can (OMC) Campaign indicated that the campaign is an effective way to change the HIV and gender related behaviours and attitudes of men and women at both the individual and community level. Significant numbers of OMC participants reported getting tested for HIV, witnessing and responding to gender based violence and using condoms at higher levels than prior to their involvement in the OMC activities. A quarter (25%) of participants got tested for HIV and 61% increased their use of condoms following participation in the programme.

Sonke's work is also leading to shifts in attitudes about gender in other parts of the country. Before a workshop in Ekukhanyeni Tribal Authority, 63% of respondents believed that, under some circumstances, it is acceptable for men to beat their partners. After the workshop, 83% of respondents disagreed with this statement. Moreover, 96% of respondents believed they should not interfere in other people's relationships, even if there is violence, but after the workshop, everyone agreed that they should interfere (Ecory's Report, 2012).

Source: Sonke Gender Justice and OMC Evaluation Report 2009

There is a growing movement of men's organisations that recognise and support the women's movement for the benefit of women, men and all of humanity. However, such organisations have been criticised over the years as some feminists argue that men should not be telling women's stories (National Organisation for Men Against Sexism, 2008). Despite such views, most organisations working in GBV now understand that men play an integral part in achieving gender equality. In regards to GBV, men can be part of the problem as the main perpetrators of violence against women, but they can also be seen as part of the solution. Thus engaging men is a relevant and much needed part to the puzzle. Empowering women and engaging men to change their behaviour is the only way to accelerate efforts to end VAW.

Case study: Engaging men to end GBV in Limpopo - Munna Ndi Nnyi?

Background

Munna Ndi Nnyi? (MNN) (Who is the Real Man?), is a registered non-profit organisation operating in the largely rural Vhembe District. The project began in 1997 as a collaboration between doctors and nurses at Tshilidzini Hospital who recognised the need to promote greater involvement of men in maternal health and child support issues.

With a particular focus on mobilising men and boys, and emphasising the interlinking issues of culture, health, poverty and moral regeneration in relation to GBV, MNN is a strong model for grassroots community-driven social change as it works to promote positive gender norms and



Munna Ndi Nnyi offices. *Photo by Mathew Willman*

relations. It achieves this through targeting traditional and religious leaders and by increasing public awareness and access to support services in the community.

Programme description

MNN employs a holistic combination of strategically interlinked and inter-run programmes to tackle the broader mission of addressing the colliding issues of GBV, HIV and AIDS and poverty. MNN's GBV-related programmes include:

Victim Empowerment Programme (VEP): This programme aims to address the issue of gender-based violence, particularly domestic and intimate partner violence and its impact on women, children and men in the broader community. Five skilled lay counsellors provide face-to-face counselling and support. They also undertake campaign and advocacy work through workshops and outreach in the community to prevent GBV and empower victims and survivors in the community to access support and justice.

Men's Forum (currently sporadic event-based funding by DSD and DOH only): The MMN Men's Forum programme, under VEP, focuses specifically on mobilising and supporting men and boys to take the lead in addressing the causes and outcomes of gender-based violence in the community. This programme conducts education and awareness raising activities, provides lay-counselling to male perpetrators and victims of abuse, and engages men who are traditional, religious and community leaders in dialogue and training to influence gender norms and raise awareness of the issue of GBV.

Alcohol and substance abuse: MMN is currently negotiating to form a partnership with the South African Anxiety and Depression Group (SADAG). MNN seeks to increase its capacity to provide support groups and referrals for alcohol and substance abusers. Research shows that alcohol and substance abuse is one of the driving forces of the twin epidemics of GBV and HIV and AIDS.

Restorative justice: The organisation adopted the restorative justice approach and an emphasis on rehabilitation and reintegration of offenders. MNN is currently developing a government accredited young offender diversion programme in partnership with other stakeholders.

Radio and print media campaigns for education and awareness on GBV: Throughout 2012 MNN conducted regular weekly Phala Phala FM (funded by Brothers for Life) radio shows which addressed GBV and related issues. MNN also aired these on local UNIVEN Radio. MNN also received coverage on issues of GBV and circumcision/HIV and AIDS in local and provincial print media including The Limpopo Mirror, Capricorn Times and Ngoho News.

Table 8.2: MNN statistics

Activity 2012	Number
In office clients seen	507
Community members accessed through VEP campaigns, school visits and workshops	19 228
Total recorded community members accessed through MNN VEP	19 735

Staff

Staff members include: social auxiliary worker, lay counsellors and a registered nurse.



The team at Munna Ndi Nnyi? *Photo by Mathew Willman*

Partnerships

MNN partners with Thuthuzela Care Centre (Tshilidzini Hospital), SAPS, South Africa Legal Aid, DSD, SASSA, Small Claims Courts, Department of Home Affairs, Traditional Leaders/Tribal Authority, SADAG, Thohoyandou Victim Empowerment and other VEP stakeholders.

Funding

MMN's VEP programme is exclusively funded by the Department of Social Deve-lopment with some additional support, such as the Brothers for Life-funded weekly radio slot on Phala Phala FM.

Achievements

MNN is known throughout the Vhembe District. It has prompted strong community dialogue and changes in accepted norms and behaviours around masculinity and the role of women and gender relations. Through advocacy and education, MNN has secured a significant position on the Limpopo map as far as engagement of men to end VAW.

MNN has been involved in monitoring and training at traditional initiation schools, resulting in a drop to zero fatalities in the last two years, compared to 24 in KwaZulu Natal alone in 2012 (AFSA, 2012).

Challenges

A lack of funds has impeded effective implementation of some projects. This has also debilitated MNNs ability to follow-up with clients. It often encounters clients in need of basic amenities such as food and clothes; however, the organisation is not in a position to meet any of those needs. The lack of stable funding means it is also unable to acquire and retain qualified staff members. MNN also encounters issues with violent, self-harming or intoxicated clients.

Initiatives led by local community-based organisations remain vital to addressing VAW. Organisations like MNN have familiarity with the dynamics of local culture and how they interplay with gender equality. More effective men's mobilisation will require more partnerships between local CBOs like MMN and larger national men's groups like Sonke. Sonke's programmes engage men at national level and they have a regional and international reach. Given Sonke's level of expertise and capacity, it becomes imperative for it to help build the capacity and enhance the work of other locally-based organisations such as MNN. These groups remain hindered because of limited government funding and lack of expertise to execute complicated work. For example, Sonke has provided technical support to MNN so it can begin working with traditional leaders using the relationships they have with local male circumcision schools.

Health personnel training

Any training for medical practitioners needs to cover all forms of gender violence and their subsequent possible health consequences. Health workers receive training to improve services for abused patients. Improvements in medico-legal practices and services related to rape and sexual assault, especially better documentation of injuries, can lead to higher conviction rates.

GBV and the media

As established earlier, the media can either be part of the problem or part of the solution in fighting GBV.

The media is a potentially powerful tool in fighting GBV because it not only reports on society but also helps shape public opinion and perceptions. It is a key conduit for making GBV visible, advertising solutions, informing policy-makers and educating the public about legal rights and how to recognise and address GBV.

Case study: Media campaigns by different actors to raise awareness



The NPA information desk at a 365 Days Conference in South Africa. *Photo by Jan Moolman*

1. National Prosecution Authority (NPA) Legal Features

NPA participated in a public education campaign in partnership with SABC Education. The campaign ran on 15 SABC radio stations and the format of the shows allowed for listeners to engage and ask questions to legal prosecutors about topics connected to VAW.

Content

The NPA Legal Features campaign covered key topics including bail and bail conditions, maintenance, prosecution of rape, understanding the criminal justice system, domestic violence and asset forfeiture.

Outreach

The NPA campaign reached approximately 30 million listeners throughout the entire country in all the official languages.

Replication or scale-up

Due to the overwhelming success of this campaign in achieving the organisation's communication objectives, the NPA will consider extending it to community media for even wider access to the public.

Source: NPA Report 2011-2012

2. Everyday Heroes Campaign



Photo Courtesy: http://www.everydayheroes.org.za/about_eh.html

The Everyday Heroes concept is the brainchild of the Department of Social Development in partnership with United Nations Office on Drug and Crime (UNODC). The concept comprises of six sets of cartoon stories on victim empowerment related topics. The campaign championed by the DSD covers topics including domestic violence, human trafficking, abuse of persons with disabilities, abuse of older persons, sexual assault and sexual abuse of children.

The Everyday Heroes cartoon project seeks to create awareness among the South African communities on the evils of gender-based violence and the consequences thereof. The campaign is geared to encourage and mobilise communities to be active and to act against crime and domestic violence amongst communities.

The Department of Social Development (DSD) officially launched the Everyday Heroes Brand awareness campaign on 8 September 2011 at Polokwane Welfare Complex. Following the launch of the project in Limpopo Province, stakeholders implemented a massive roll out of activities throughout the other provinces in the form of road shows.

DSD is in the process of translating the stories into all 11 official languages, which will be printed as booklets. It also plans to create a television series on the VEP cartoon stories to reach a wider audience. Various Drama themes developed from the cartoon booklets will soon be performed during the provincial road shows.[37]

[37] http://dsdupdates.wordpress.com/2011/08/29/65/

Secondary prevention

National SAPS training

The provision of training to police remains a crucial element for ensuring that SAPS improves on services rendered to victims of sexual offences, domestic violence, offences against children and other victims of crime. The NAP also provides for all police stations, in cooperation with provincial training managers and the Division Human Resource Development, to set annual targets for training members in the Domestic Violence, First Responders to Sexual Offences, Victim Empowerment and Vulnerable Children learning programmes.

During 2011-2012, SAPS participated in a regional training workshop with the United Nations Office on Drugs and Crime (UNODC) as coordinators on the development of the Effective Law Enforcement, Responses to Violence against Women in the Southern African Region, particularly domestic violence. It also presented the Violence against Women and Children course to the Southern African Regional Police Chiefs Cooperation (SARPCCO) task team at a work session in Pretoria. This was part of the SAPS and South African government's commitment to assist SADC in addressing GBV within the region.

According to the annual performance plan 2011/12, the SAPS committed to foster the knowledge and skills of personnel through the following courses.

Table 8.3: SAPS course statistics

Activity 2012	Number of courses	Number of members to be trained
Victim Support (effective support to victims of crime)	191	3 820
Violence against woman and children	470	9 999
Total	661	12 819

Training of service providers by NPA

Stakeholders reviewed the training manual for sexual offences and included relevant additional sections (inter alia on the CJA and Children's Act and case law). They then developed a detailed programme and manual which caters for topics such as social context, child witnesses, mind maps of Sexual Offences Act, medical examinations and investigations. The team included a joint group of experts from the SOCA, SAPS, the Department of Health and the DSD (DOJ&CD annual report 2011-12).

Training of justice personnel

In the financial year 2011-2012, NPA SOCA conducted multidisciplinary training on the investigation and prosecutions of sexual offences cases. The training courses included advanced skills on prosecuting the child sex offender, child pornography training seminars and integrated training for case managers, victim assistance officers, site coordinators and relevant stakeholders involved in TCCs and SOCs.

Forty-five delegates, including doctors, advocates and investigators, attended the technical assistance training programme in March 2011 in Maputo.[38]

The department also developed the training manual on criminal law (sexual offences and related matters) Amendment Act 32 of 2007. The department conducted subsequent training for 645 prosecutors in 23 training sessions in all provinces.

Training for prosecutors

In 2011-2012 the SOCA team delivered five training sessions on the Domestic Violence Act attended by 108 prosecutors.[39] The SOCA also established a

[38] http://www.justice.gov.za/VC/events/2012natconf/paper_npa.pdf
[39] http://www.npa.gov.za/UploadedFiles/NPA%20Annual%20Report%202011-12%20Final%20Copy.pdf

partnership with information and systems management in the DOJ&CD National Operations Centre (NOC) to develop an electronic and standardised case management system for domestic violence matters specifically in relation to protection orders, but also those offences linked to GBV.

Conclusion

As with other social problems, GBV has largely been addressed and understood through responding to the aftermath of such violence. Prevention efforts, to the extent they have existed, have largely been driven by the women's movement. These have focused on changing social norms, building individual empowerment and addressing underlying structures that perpetuate VAW. The primary focus, however, has been at the level of response. Various prevention strategies have been noted to tackle VAW. These include political commitment, public awareness campaigns, education and economic empowerment. Engaging men to challenge negative gender norms that promote violence against women is another strategy of primary prevention that has been proven to achieve positive results.

There is often, however, a fine line between prevention and response. Each can enhance the effectiveness of the other. For example, strong laws and sanctions against GBV can have a preventive effect. Strong rehabilitation programmes for perpetrators of GBV can help to ensure that they do not become repeat offenders. Programmes of support for women that include economic empowerment can help to ensure that women do not become repeat victims, as illustrated in Murendeni's story at the beginning of this chapter.

While there are concerted efforts towards preventing GBV at the primary and secondary levels both at national and provincial levels, there has been limited evaluation of these processes, making it difficult to assess the impact of the different interventions. There is need for prevention interventions to build in monitoring and evaluation processes so we can begin to see what interventions work and replicate them to reduce the scourge. Documentation of interventions at community level is also critical in assisting the replication processes. It is apparent that many efforts have not been documented.

CHAPTER 9
INTEGRATED APPROACHES

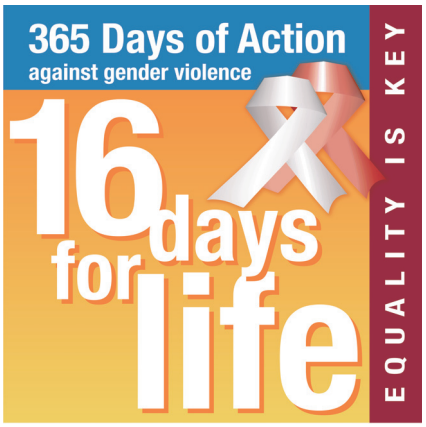


Multi sectoral reference group set up to guide the Limpopo violence against women baseline research. *Photo by Gender Links*

Key facts

- South Africa has a National Action Plan for addressing GBV that was launched in 2007.
- Major challenges to the implementation of the NAP has been the lack of budgetary allocations and limited decentralisation to provincial and local government levels.
- The National GBV Council was inaugurated to ensure the implementation of the NAP.
- Integrated Victim Empowerment Policy (IVEP) recognises the importance of victims and all stakeholders, both in the public and private spheres, who deliver services to victims.
- Only two of the five TCCs located at hospitals remain fully operational namely Tshilidzini and Mangkweng TCC.
- In the period 2011-2012 Tshilidzini handled 420 sexual offences and 1096 DV cases.
- The ZTVA model is an example of a community based integrated approach for addressing GBV.

In May 2006, government and civil society stakeholders gathered at Kopanong to develop a National Plan of Action to end GBV. The conference led to two outcome documents: the Kopanong Declaration and the National Action Plan to End Gender Violence (NAP). Participants acknowledged that GBV is a complex issue which calls for strategically coordinated policies and actions augmented by the participation of both the government and civil society.[40]



This chapter focuses on integrated approaches facilitating a multi-sectoral response to GBV at national, provincial and local levels. It elaborates on structures exhibiting multi-sectoral collaboration between health, police, courts and social services to provide quality, sensitive treatment to victims at all three levels. Stakeholders taking part in desktop research and primary qualitative data collection derived evidence from these policies or structures.

The 365 Day National Action Plan to End Gender Violence

The Kopanong Declaration acknowledged that the 16 Days of Activism is not sufficient to address GBV and that a more comprehensive and sustained approach is necessary, including prevention, support, and response. The proposed NAP set targets, indicators and timeframes through which to monitor the impact of interventions addressing violence against women and children (by both government and civil society).

The plan is anchored on the recognition that no single sector, government ministry, department or civil society organisation is by itself responsible or has the singular ability to address this challenge. It is envisaged that all the South African government departments and civil society organisations will act as stakeholders and use this National Action Plan as the basis to develop their own strategic and operational plans to ensure unity of purpose and cohesion of efforts to achieve maximum impact in the process of eradicating this scourge.[41]

Evaluation of the 365 NAP

The Commission for Gender Equality (CGE) undertook a project in 2012 to monitor the implementation of the NAP. It set out to determine the extent to which the 365 Days campaign has been implemented since inception and identify key constraints and gaps in the implementation of the NAP and establish the effectiveness of programmes.

Since the official launch, proper implementation of the plan is still fragmented and uncoordinated. One major impediment has involved allocation of resources for implementation, especially given that when stakeholders launched the plan they did not conduct a budgetary vote for it. Other limitations include the level of civil society engagement and the lack of comprehensive monitoring and evaluation strategies for the plan (365 Day National Action Plan to End Gender Violence, 2007).

The National Council against GBV

Deputy President Kgalema Motlanthe launched the National Council against GBV on 10 December 2012 in Rustenburg.[42] Motlanthe chairs the council, which is championed by Minister of Women, Children and People with Disabilities Lulu Xingwana.

The council is a national multi-sectoral structure composed of 20 members from government and civil society. Sectors represented in the council include civil society organisations dealing with violence against women and children, religious organisations, traditional leadership, members of the women's

[40] http://www.unicef.org/southafrica/SAF_resources_365daysdeclaration.pdf
[41] http://www.unicef.org/southafrica/SAF_resources_365daysdeclaration.pdf
[42] http://www.services.gov.za/services/content/news/GenderBasedViolence/en_ZA

movement, academic and research institutions and government across all spheres and the South African Local Government Association.

The council has a mandate to provide strategic guidance and to monitor the implementation of all programmes dealing with the elimination of GBV in the country. More specifically, the council has been charged with the following responsibilities:

- To drive the implementation of the 365 Days National Plan and advise government on policy and intervention programmes;
- To strengthen national partnerships in the fight against gender-based violence;
- To create and strengthen international partnerships on gender-based violence; and
- To monitor and report progress on initiatives aimed at addressing gender-based violence.



Minister of Women Children and People with Disabilities Minister Lulu Xingwana briefs media on gender-based violence and turn-around strategy. *Photo courtesy of Google Images*

The NPA Sexual Offences and Community Affairs (SOCA) and management of the Thuthuzela Care Centres (TCCs)

The SOCA develops strategy and policy relating to sexual offences, domestic violence, human trafficking, maintenance matters and young offenders. Thuthuzela[43] Care Centres (TCCs) offer an integrated, progressive approach to addressing sexual violence, prevention, service provision, and support of rape survivors. TCCs are one-stop facilities for managing sexual assault cases and South Africa introduced them as part of its national anti-rape strategy. The facilities aim to reduce secondary trauma, improve conviction rates and reduce the cycle time for finalising cases at court level.[44]

South Africa has two TCC models: the medico-legal and hospital-based models. Different management structures and resource allocations characterise each.

The medico-legal sites tend to be standalone centres that provide services beyond sexual assault care. The goal of the TCC model is to effectively address the medical and social needs of sexual assault survivors, reduce secondary victimisation, improve conviction rates and reduce the lead time for finalisation of cases.[45]

Located in public hospitals, the hospital-based models aim to provide survivors with a broad range of essential services - from emergency medical care to counselling to court preparation - in a holistic, integrated and survivor-friendly manner. Services offered by the TCCs include: reception and comforting of client; information counselling on services and procedures; history taking and medical-legal examination; prophylaxis and treatment for pregnancy, STIs and HIV; bath or shower, refreshments and change of clothing; transportation home or to safe shelter; referrals; and follow-up support.

[43] *Thuthuzela*, an IsiXhosa term meaning "comfort", used in the context of providing a caring environment in the midst of hurtful experiences experienced in rape and sexual assault cases. According to the NPA SOCA Unit, the word "comfort" awakens feelings of warmth, freedom from emotional and physical concerns, safety, and security, being pampered and cared for and, above all, reinforcing dignity, hope and positive expectation, all of which are attributes and feelings that are realised in the establishment of the Thuthuzela Care Centres.

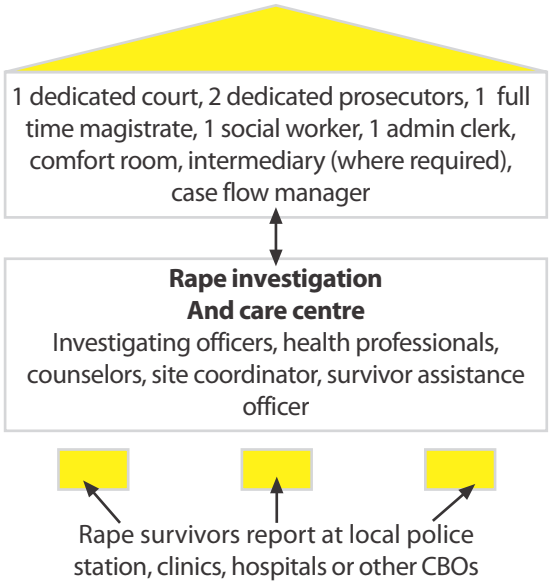
[44] NPA, 2010.

[45] NPA, 2010 www.npa.gov.za

Figure 9.1: Thuthuzela Care Centre model

Sexual offenses court
- Prosecution of SO cases only leads weekly strategy meetings and case assessment
- Consults with survivors throughout court process
- Ensures speedier, more effective prosecutions

Objectives
- Reduce secondary victimisation
- Improve conviction Rate
- Reduce the time to finalisation of cases



Rape investigation and care centre
- Centralises all rape investigations
- Ensures prompt transportation, examination and care of survivors
- Increases communication between prosecutor, police and survivor
- Develops best practices for speedy, sensitive investigation of cases
- Ensures accurate data collection and analysis
- Immediate crisis counselling for survivors

Thuthuzela Care Centres operate best in public hospitals close to communities where the incidence of rape is particularly high. They are also linked to sexual offences courts, which are staffed by skilled prosecutors, social workers, magistrates, NGOs and police, and located in close proximity to the centres (NPA Annual report 2011/2012). Since 2010 the number of sites providing TCC services increased from 45 to 52.

Commenting on the establishment of TCCs in the rural areas, the Minister of Justice and Constitutional Development said government has already established 26 TCCs in the rural areas. Government defined a TCC as rural if the majority of the cases reported come from farming communities or rural areas.

Use of TCC services

While the police received 64 472 cases of sexual offences in 2011-2012, less than half of these survivors (28 557) accessed services at the TCCs during the same period.

Table 9.1: Change in number of cases reported at TCCs between 2010-11 and 2011-12: National

Criteria	2010-11	2011-12	Actual difference	% difference
Number of new cases (national)	20 496	28 557	8061	39.3
Number of cases designated to case managers at court (national)	9716	10 949	1233	12.7
Number of cases finalized at court (national)	1761	2180	419	23.8

Source: (NPA Annual report 2011/2012).

Table 9.2 shows an increase in the number of reported cases and improvement in case management from the 2010-11 financial years to the 2011-12 financial years. Researchers logged a 39% increase in reported cases and a 24% increase in finalised cases between the two financial years. However, less than half of the cases reported in these two years went to court and got allocated to case managers.

While the courts received 10 949 sexual offences in addition to outstanding cases, only a small proportion (2180) reached completion. These findings speak to the prolonged times currently used to complete cases and to the huge court backlogs. There is also an insufficient number of magistrates or court officials to deal with the influx of sexual offences cases.

Conviction rates

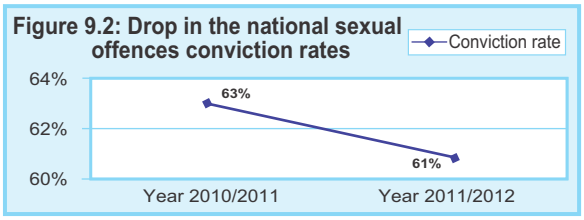


Figure 9.2 shows the average conviction rate of sexual offences prosecuted at sites linked to TCCs dropped from 63% to 61% between the two financial years (NPA annual report 2011/2012). According to the DOJ&CD annual report 2012, this drop can be attributed to various factors including case flow management being dealt with by presiding officers, a substantial drop in the number of dedicated courts, a decrease in specialised services and a considerable increase in sexual offence matters reported at TCCs.

Referrals

TCC referred more than half (57%) of reported cases to court for prosecution.

TCCs in Limpopo Province

To date, Limpopo has five TCCs: Mangkweng TCC at Mangkweng Hospital in Polokwane, Tshilidzini TCC at Tshilidzini Hospital in Thohoyandou, Nkensani TCC, Musina TCC and Mokopane TCC. Musina and Mokopane TCCs are not fully operational.[46]

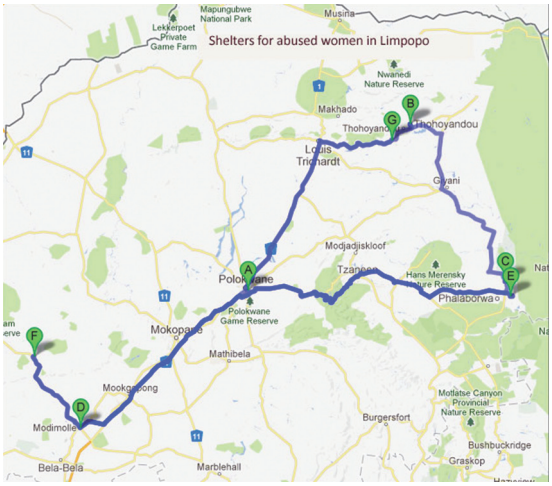


Table 9.2: Number of TCCs in Limpopo

Province	Total sexual offences reported to police 2011/12)	Number of TCCs	TCCs in Limpopo	Name of hospital	Location: rural/urban
Limpopo	5669	5	Mangkweng TCC		Rural
			Tshilidzini TCC	Mangkweng	Rural
			Musina TCC (not fully operational)	Tshilidzini	Rural
			Mokopane TCC (not fully operational)	Musina	Rural
			Nkhensani TCC (not fully operational)	Mokopane	Rural
National Total	**64 472**				

Sources: SAPS crime stats report 2011/2012; DOJ&CD Parliamentary question 1580 (June 2012).

Table 9.1 shows that the total number of TCCs in Limpopo province is not enough to cater for all the sexual offences reported to the police in the year 2011/12. Based on the number of sexual offences reported by the SAPS (2012) and the total number of TCCs in each province, approximately one victim per 1000 can access the TCC in Limpopo. This means there is a disproportionate number of TCCs compared to need.

[46] http://www.unicef.org/southafrica/protection_5080.html

Case study: Tshilidzini TCC



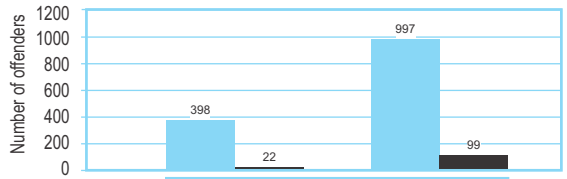
Photo courtesy of Google Images

Tshildzini TCC is situated at Tshilidzini Hospital in Thohoyandou. Services offered include shelter services and referrals to police for protection orders and/or to the magistrate court.

Shelter services

Despite being designed as a one-stop centre, over the years it has been operating as a shelter. On average, about 30-40 people report cases each month. The TCC has four bunk beds for a total of eight beds that can be used. Due to limited number of beds, in some instances victims have to share beds or sleep on mattresses on the floor, especially in the case of families (mother and children).

Figure 9.3: Sexual offences and domestic violence acts reported at the Tshilidzini TCC in the year 2011-2012



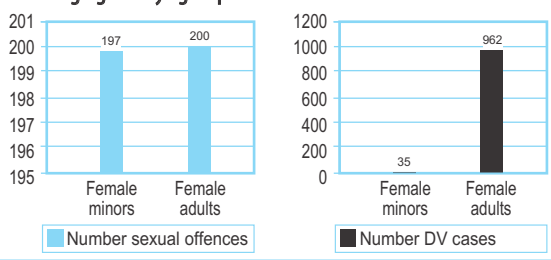
	Sexual offences	Domestic violence
Female	398	997
Male	22	99

Source: Tshilidzini TCC.

Figure 9.3 shows that between 2011 and 2012, victims reported 420 sexual offences and 1096 DV cases at the TCC. Women victims reported the majority of sexual offences cases (95%) and DV cases (91%). Overall, the number of GBV cases being handled at the centre is increasing, putting more pressure on both human and other resources such as beds and space as evidenced by some victims sleeping on the floor (Direct communication with staff member Nicholas Kwinda).

Figure 9.4 shows that almost equal proportions of adult and minor sexual offences victims report to the TCC. Adult victims accounted for 200 of the sexual offences reported in the period under review while female minors reported 197 of the cases. These statistics provide further evidence of the fact that young survivors of sexual offences comprise a large share of those accessing TCCs in the country. Adult women report the majority of DV cases.

Figure 9.4: Domestic violence and sexual offences among females segregated by age reported to Tshilidzini TCC 2011-2012



Source: Tshilidzini TCC.

Figure 9.5: PEP uptake by victims of rape at the Tshilidzini TCC 2011-2012

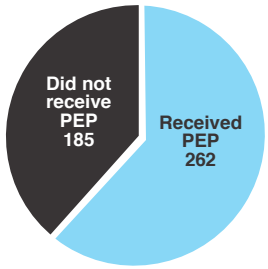


Figure 9.5 shows that more than half (62%) of those who reported sexual violence at the TCC received PEP. Survivors often arrive at the centre more than 72 hours after the incident, which is one of the reasons they may not access PEP services.

Challenges

There is currently no case manager to deal with conviction issues. Another challenge is the high rate of case withdrawal by the victims. It is common for victims to open a protection order which they later nullify - after some time victims often return to the TCC having experienced recurrent acts of GBV.

To curb this, the TCC hired social workers to assist in such matters by providing counselling and advice on legal matters. Due to this move, the number of referrals to the magistrate court and to the police has decreased since social workers deal with some of the cases. The TCC lacks office space and resources. For example, it has just four bedrooms, two of which also accommodate social workers (Direct communication with Tshilidzini TCC coordinator).

Challenges faced by Limpopo TCCs

- Victims cannot be kept for longer than two weeks in the current premises.
- There is also no clear tracking system to follow a case from when it comes to the TCC system until conviction. It complicates measuring the success of the TCC system.

The National Integrated Victim Empowerment Policy

The Integrated Victim Empowerment Policy (NIVEP) forms part of the strategic efforts of the South African government to prevent crime and to create a peaceful crime-free country. The IVEP recognises the importance of victims and all stakeholders, both in the public and private spheres, who deliver services to victims. The policy therefore provides for the coordination of all activities and efforts by various government departments and civil society. It creates a framework to guide and inform the provision of integrated and multi-disciplinary services to address the needs of victims of violent crime.

More specifically the IVEP aims to:

- Give strategic direction to those providing services to victims of crime and violence;
- Identify the roles and responsibilities of various role players; and
- Create a common understanding of victim empowerment amongst various state departments, victims, perpetrators, NGOs and CBOs and individual members of the community (IVEP Draft 2007).

Intervention strategies

The guiding principles for the NIVEP have been embodied in values that determine the nature and good quality services for victims, respecting the rights of the victims and applying the principles of both "Ubuntu" and "Batho Pele." The NIVEP has core intervention strategies based upon the concept of a victim-centred approach which avoids secondary victimisation. These strategies apply to all sectors involved in the empowerment of victims.

The National Victim Empowerment Programme (NVEP)

Victim Empowerment SOUTH AFRICA

Stakeholders created the NVEP in 1998 after the National Crime Prevention Strategy (NCPS) acknowledged the need to promote and implement a victim-centred approach to crime prevention.

They formally launched VEP in August 1998, however full implementation only started in January 1999. This programme aimed to make integrated criminal justice victim-friendly and to abate the negative effects of crime and violence on the victims.

To ensure integrated and coordinated services between government departments (at various levels) and civil society, the NVEP is comprised of various structures. These include an integrated inter-sectoral Victim Empowerment Management Team (VEMT) consisting of representatives from the national departments of health, correctional services, justice, education, SAPS with social development as the lead and coordinating department.

The VEMT is responsible for determining the strategic direction with regard to the management of the NVEP and to ensure that respective departments address all issues pertaining to victims. The following table shows the different roles of the departments within the VEMT.

Table 9.3: Departmental responsibilities within the VEP	
Department	**Responsibility**
The Department of Health	Providing a professional and accessible service to victims of crime and violence who approach hospitals, clinics, primary health care centres or crisis centres for assistance.
The SAPS	Providing a professional and accessible service to victims/survivors of crime and violence during the reporting and investigation of crime.
The Department for Social Development	Coordinating the roles across the relevant departments.
The Department of Justice and The National Prosecuting Authority (NPA)	Responsible for the professional treatment of victims of crime and violence, and witnesses to facilitate optimal participation on the criminal justice process.
The Department of Education	Prevents the victimisation of children in the school environment. In the event of victimisation the departments facilitates immediate access to other relevant support structures (such as the SAPS and Social Development) act against perpetrators, protect child against further victimisation.
Civil Society Organisations (CSOs)	In partnership with government, civil society plays a major role in advocating for victims' rights and providing services to victims. Other CSOs are involved in increasing and expanding the frontiers of knowledge in the field of victim empowerment, especially in the area of crime prevention, trauma and post-traumatic stress disorder.

Source: Parliamentary Monitoring Group.

The integrated service delivery model is used to meet such a holistic demand. The levels/methods of services rendered address the victim's physical, psychological, social, educational and emotional needs.

1. ***The primary prevention method*** includes primary methods which aim to stop violence before it occurs. Services rendered should be preventative in nature and in the form of awareness campaigns and advocacy programmes. Staff members conduct various outreach programmes to create better community awareness of those crimes affecting victims, and to allow them to take responsibility for addressing the problem and also acknowledging that violence is not a domestic problem, but a community problem. This can be facilitated by distributing promotional material and pamphlets.
2. ***Early intervention methods*** include parental skills development, debriefing and defusing, therapeutic services focusing on empowerment of women and children exposed to mild or moderate domestic violence within the onset phase of gender-based violence. Staff members empower women with knowledge about their rights and about domestic violence, sexual assault and abuse based on the outcome of the IDP/IAP developed during the victim and the social worker's contact.
3. ***Statutory services*** include all court services rendered in the form of court reports at pre-trial and pre-sentencing stage. Services include referral for protection order as well as the compilation of victim impact statements. Statutory services are categorised into:
   a) Sexual assault cases: pre-trial and pre-sentencing reports addressing the developmental stages of a child victim, as well as the impact of the trauma on the victim. The child should be accompanied by a responsible adult family member.
   b) Domestic violence cases: victim impact statements are completed and submitted to court, referral and assistance in terms of application for protection orders, divorce and custody matters.

c) Human trafficking cases: court reports clearly state the assessment in terms of identifying the victim and indicating the impact of trauma on the victim.
d) Child abuse cases: in terms of child abuse cases and children with behavioural problems, assessments at the centre seek to observe the behaviour of the child and render rehabilitation programmes. Once that has been done, a report is compiled for the children's court with recommendations related to the future of the child. This reflects the findings and observations of the centre staff.

4. ***Continuum of care services/methods*** include shelters to accommodate women and children affected by gender-based violence, children under the age of 18 affected by sexual assault, sexual abuse and human trafficking. Services rendered include those of a multi-disciplinary approach that is constituted by: social workers, permanent/contracted psychologists, nurses/doctors, court preparation assistants, prosecutors and police, all working in a multi-disciplinary team to assist victims to prepare and mount successful cases for prosecution.

Figure 9.6: The NVEP victim centred approach

South Africa Department of Social Development
Overview of the Victim Centered Approach

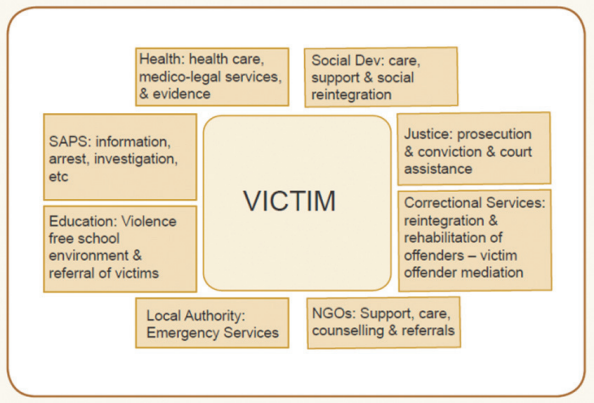


Figure 9.6 demonstrates how the different departments work in unison within a victim centred approach. The partnership between various government departments and civil society on service delivery to victims of crime is prerequisite to the success of the integrated VEP. Each structure is expected to develop its own strategies to address the needs of victims. Such strategies should be coordinated within the department and between relevant departments to ensure a holistic approach to service delivery with no duplication of services and service delivery, thus ensuring optimal use of the limited resources (Integrated Victim Empowerment Policy Draft, 2007).

Evaluation of the VEP programme by UNDOC

The VEP has encountered various challenges since inception, some of which include the lack of monitoring and evaluation mechanisms and inadequate facilities for victims of crime and the broad geographic spread of such facilities. A glaring gap is the inadequacy of shelters to accommodate victims in the rural areas.

Victims do not always receive the type of services they deserve and high staff turnover hampers effectiveness and progress. The programme is short-staffed and the counsellors and social workers currently available do not tally with the number of victims.



Polokwane Victim Empowerment Centre poster.

Lack of a strong communication and marketing strategy has also impeded the effective administration of the programme. Although the programme has managed to strengthen coordination between government departments and CSOs, several other relevant departments have not been fully involved. For instance the Department of Education is not actively participating in VEP activities. However, over the years government has made efforts to strengthen the programmes (UNODC - South Africa's Victim Empowerment Programme - Final Independent Evaluation).



Photo courtesy South Africa Government Online

Victim empowerment at provincial level - Limpopo Department of Social Development

One stop centres

The National DSD department has established one stop centres as part of the VEP. These centres offer integrated services to victims of violence, abuse and crime. Unlike shelters, one stop centres only provide emergency accommodation.

The centres also provide a range of services such as counselling, medical attention, legal advice and support for survivors of violence. They also offer rehabilitation services, including counselling and support groups for male perpetrators as well as potential perpetrators in order to break the cycle of violence. After assessing each situation, victims can be referred to a shelter if it is too risky to send them home. The Khuseleka one stop centre, the only one stop centre in Limpopo, is explored in further detail in the next case study.

VEP case study: Khuseleka One-Stop Centre

The Khuseleka model is a multi-sectoral approach being implemented by the Department of Social Development in collaboration with the UNODC and EU under the Victim Empowerment Programme. Other key government departments and institutions include the Departments of Justice and Constitutional Development, Health, the National Prosecuting Authority (NPA), South African Police Services and civil society organisations. Adapted from existing models, Khuseleka stands as a good example of a partnership between government, development agencies and civil society organisations in the country.

The name Khuseleka is derived from the Zulu word which means protection. The centre is an initiative of the Department of Social Development's VEP that came about as a way of responding to the needs of women and children, especially in poor black rural areas and communities that experience GBV.

Services

The 24-hour centre aims to provide integrated services for women and children victims of violence, such as trauma counselling and psychosocial support, health care, police services, legal assistance and shelter services.

Medico-legal services include ensuring medico-legal professionals have been based at the centre. These people can assess the physical condition and obtain baseline vital signs, take a brief history of events, take a sexual assault kit, conduct on-site HIV testing and counselling, provide pre- and post- counselling advice and providing documentation to the victim. All these would be applicable if, and only if, there is commitment from all the core stakeholder departments.

Capacity
The centre currently has the capacity to house up to 30 adults and 12 children for up to six months.

Funding
The centre is not only budgeted for by the Department of Social Development, but all the core stakeholder departments contribute in the form of remuneration and use of human resource and service tools used at the centre. The business sector also plays an important role by donating in kind. Some community members also make donations.

Partnerships
Adapted from existing models, Khuseleka stands as a good example of a partnership between government, development agencies and civil society organisations. Other key government departments and institutions involved in running the centre include the Departments of Justice and Constitutional Development, Health, the National Prosecuting Authority (NPA), South African Police Services and civil society organisations.

Achievements
The centre has conducted successful awareness campaigns for prevention and advocacy programmes. It successfully reached 1762 people during the crime victims' rights week in September 2012 and 2876 people during 16 Days of Activism from 25 November - 10 December 2012. It also participated in the Take Back the Night Campaign at which one of the survivors from the centre confidently addressed the crowd about taking charge and control on preventing and bringing about a paradigm shift by breaking the gender-based violence cycle.

Challenges
While the one stop centre model is supported at national level, there remains a lack of buy-in and understanding of the department roles needed at the provincial level. Other challenges include slow pace in police case investigations and lack of competency among some support staff.

Replication
Stakeholders have plans to open multiple one-stop centres across South Africa. The Khuseleka One-Stop Centre represents the first of many in all nine provinces. On 5 October 2011, Minister Bathabile Dlamini officially launched the Limpopo Khuseleka centre. On 29 November 2011, stakeholders in Vryburg, North West Province, launched the second one-stop centre there. Others now exist in Gauteng, Eastern Cape, Northern Cape and Mpumalanga.

Next steps
The next major step required is the establishment of the centre advisory board, which should constitute members from the core stakeholder departments. The centre also needs to recruit volunteers for general support.

Adapted from the 2013 SADC Gender Protocol Summit and Awards submissions

Coordination by the LDoH

At a provincial level, Irish Aid is working with the Limpopo Provincial Department of Health and Social Development (LPDOHSD) and NGOs to support their responses to GBV. The LDoH assists in planning and implementing programmes geared towards a provincial campaign that will strive to:

- Increase coordination and improve relations between government and civil society within the province;

- Strengthen capacity of the department to mainstream gender and contribute to efforts aimed at reducing violence;
- Strengthen community structures to better respond to violence against women; and
- Educate people on the issue of GBV and challenge the negative attitudes and beliefs that perpetrate GBV in Limpopo.

In addition, Irish Aid is also funding the training of health care officials in the province to enable them to properly gain evidence in the immediate aftermath of rape.

Zero Tolerance Village Alliance Project in Vhembe and Mopani: Partnership between LDOH, TVEP and GL to prevent GBV at a community level

The ZTVA programme is aimed to enable behavioural change by building empowered and supportive environments in which victims of sexual, domestic and child violence, and People Living With HIV and AIDS (PLWHA), feel secure to speak out and exercise their rights. The process involve training community based organisations (CBOs) to undergo seven day training on the ZTVA model. Training exercises provide each CBO participant with the skills and knowledge to support the required ZTVA implementation activities. Activities include holding workshops, community dialogues, door-to-door campaigns and focus group discussions. Positive results and the change in behaviour have been observed in the participating villages.

Case study: Description of TVEP's Zero Tolerance Village Alliance (ZTVA) prevention training



The ZTVA is a holistic approach to the eradication of gender and child violence. The strategy targets all elements of "hot-spot" villages, to ensure that everyone in the community is empowered on their rights and responsibilities. The project includes the establishment of safe houses and support groups and aims to generate community pride as a means of combating crime. It requires male role models to take a public oath committing them to the eradication of gender and child violence, following which they will be awarded a Badge of Honour. Women who have "broken the silence" will also receive a Badge of Courage at the same ceremony.

Break the Silence campaigns, plays and public sensitisation workshops

The campaign trains volunteer campaigners (Advocacy Officers) to mobilise communities in the ZTVA villages and respond to requests from community structures such as traditional councils, schools and churches. Interventions include campaigns, workshops and/or plays performed by unemployed youths. The organisation has fostered good working relationships with national and community radio stations and newspapers.

Help desks

The campaign places volunteer advisors at nine rural clinics and at the central office in Sibasa. The role of the volunteers is to:

- Promote the Break the Silence ethic and encourage access to ART;
- Identify orphans and vulnerable children and refer accordingly;
- Facilitate access to safe pregnancy termination services, female condoms, social grants and/or food parcels; and
- Report abuse or malpractice.

Survivor workshops
The team invites women and youths who report family violence to either of the trauma centres to a series of two workshops at which they learn about their rights as well as coping skills. Transport is provided and participants can bring a friend or family member as company.

TVEP's "Survivors Rights" publications
The coordinators of this project realise that for a message to be sustainable it must be incorporated into the Life Skills curriculum for all schools. To this end, TVEP has developed and piloted workbooks for learners in partnership with the Department of Education. In order to also cover younger children, and to encourage reporting of child abuse, TVEP builds the capacity of educators at crèches and preschools and provides them with educational posters. It also distributes stickers carrying appropriate slogans to the children and information leaflets on child abuse (in the two languages spoken in the region) to parents.

Sustainability and partnerships
TVEP has partnered with the trauma centres under the Department of Health since 2001 and formed partnerships with government departments such as Social Development, Home Affairs, South African Police Services and the Department of Public Prosecution. This work has demonstrated that the ZTVA model can be rolled out to many villages. The partnership has also afforded TVEP the value-added outcome of collaborating with other Vhembe district CBOs, thereby reducing the duplication of efforts while ensuring that quality service is provided to clients by all organisations. The project has also benefited the five targeted CBOs as they have been given the opportunity to participate in capacity-building exercises previously unavailable to them.

Achievements
TVEP and ZTVA teams have made significant progress in assimilating contextually-appropriate interventions and services into existing population groups. Partnerships created with police, government and like-minded CBOs have resulted in swift adoption by stakeholders. The ZTVA model is adaptable for use in other regions where traditional leadership is at odds with government mandates.

Main challenges
- Funding continuity;
- Human resource constraints;
- Technology limitations;
- Geographic access to marginalised regions;
- Dissonant ideologies between village leadership; and
- Sustained participation of chiefs.

Source:TVEP

Conclusion

Stakeholders have implemented several integrated approaches to fight GBV at national and provincial level that engage both government and civil society. These include the National GBV council, the 365 Day NAP, the IVEP and the Thuthuzela care centres. Despite these structures, widespread incidences of GBV remain

common and many survivors struggle to access the TCCS and one stop centres run as part of the VEP programme.

Challenges in operating and coordinating integrated structures and policies include lack of funding for the structures, poor harmonisation among structure members and poor monitoring and evaluation systems.

Some of the structures also remain inadequate and ineffective, including the TCCs, which refer less than half of GBV cases to the courts. This can act as a deterrent to survivors looking for justice or access to services. National level conviction rates for sexual offences have also decreased, which is another significant challenge.

Victims report more cases of domestic violence than sexual offences at TCCs, including the Tshilidzini TCC. Mostly women use the TCCs, but the number of female minors reporting cases is similar to the number of adult women. More than a third of survivors fail to access PEP, mainly due to the fact that they report to the TCC too late.

While the Khuseleka One-Stop Centre is ground breaking and the model is being rolled out to the rest of the country, there remains a great need for better and further coordination of VEP-related initiatives at provincial level.

CHAPTER 10
CONCLUSIONS AND RECOMMENDATIONS



Everyone has a right to safety and security.

Photo by Colleen Lowe Morna

Extent

Conclusions

- Surveys show Limpopo has high prevalence of IPV both in lifetime in the 12-month period before the survey. More than three quarters of women (77%) and 48% of men reported experience and perpetration, respectively, of some form of GBV at least once in their lifetime.
- Emotional IPV is the most common form of GBV and yet this is not usually addressed or reported in administrative data.
- Researchers noted high levels of underreporting of GBV as the majority of women who experienced physical IPV or rape by a non-partner did not report this to the police or health care facilities.
- Disaggregating the prevalence of the different forms of GBV by province shows that GBV dynamics are not homogenous throughout the country. Limpopo recorded the highest GBV experience by women and the second highest perpetration by men.

Recommendations

- Prevention efforts at provincial level need to be accelerated and particular attention given to raising awareness among women.
- Provision of psychosocial support should be prioritised and scaled up in responding to GBV.
- More resources should be allocated towards a health sector response that places importance on mental health services.
- Further research is imperative to understand the underreporting of GBV in Limpopo. Service providers including police and health facilities need to improve on victim-friendly service delivery.
- GBV campaigns need to empower women and encourage them to speak out and seek help.
- It is necessary for future research to investigate why women in Limpopo show more reluctance to report IPV and non-partner rape compared to their male counterparts.
- Provincial statistics from this report should be used to gauge the levels of GBV across the country and inform programmes.
- To minimise further amplification of GBV in hotspots like Gauteng and Limpopo, which has shown higher levels of violence, there is need to accelerate interventions to curb abuse within intimate relationships. In addition, future research is needed to establish the determinant factors that fuel violations of women's rights in the province.

Patterns and drivers

Conclusions

- The study found that age, education and employment status are not significantly associated with IPV experience and perpetration, but significantly associated with non-partner rape.
- Child abuse experience and alcohol consumption by men seem to increase the risk of adult IPV perpetration.
- Women and men in this study exhibited conventional attitudes towards gender relations that tend to drive VAW. Both women and men express acceptances of gender equality in the public but do not conform to this equality in the home. Gender attitudes of men and women are predominantly conservative and what is conspicuous is that not only do men confirm these and conform to them, women also strongly perpetuate attitudes that result in repression of their rights and freedoms.

Recommendations

- GBV prevention campaigns need to consider and target the identified risk groups. In particular, workplace-based initiatives will go a long way in targeting employed men, who are more likely to be perpetrators of non-partner rape.
- There is need for child rehabilitation programmes for abused children coupled with campaigns advocating for reduction of child abuse. Prevention of child abuse may ultimately contribute to prevention of GBV perpetration.
- GBV is perpetuated by a male chauvinistic society that tends to propagate women's subordination. Thus there is a need to engage not only men, but also boys from a younger age, socialising them about gender equality. The government can continue streamlining the education curriculum from primary level to include education about

positive gender attitudes that can promote a culture that does not tolerate violence against women.

Response

Conclusions

- The DVA places responsibilities on only one department, the SAPS, yet it places no corresponding legal obligation on other relevant stakeholders such as the DSD and the Department of Health.
- The data is also not reflective of the number of cases withdrawn by women. As such it is difficult to make inferences about the use of services by GBV survivors.
- Some of the challenges impeding the goal of eliminating violence include lack of dedication and efficiency by key role players in the criminal justice system. This is illustrated in several personal accounts detailing survivors' negative experiences with police.

Recommendations

- There is need for legislative enforcement on the responsibilities of other departments such as DSD, Department of Health and the Department of Housing as far as the effective implementation of the DVA is concerned.
- Data on GBV from the Department of Health, the SAPS and DOJ&CD is not disaggregated by age, sex or by type of GBV.
- More training needs to be conducted with personnel who deal with victims and survivors of violence.

Support

Conclusions

- Limpopo does not have enough shelter services proportionate to the need for them. Even fewer second and third stage shelters exist, leaving women who leave first stage shelters stranded with nowhere to go.
- Both women and men are relatively unaware of the DVA and provisions for protection orders.
- Administrative data falls short in depicting the true extent of GBV within the Limpopo province.

Recommendations

- Government should allocate more resources to existing shelters and for the establishment of new shelters, especially second and third stage shelters.
- Public awareness campaigns should aim to sensitise communities about the DVA and GBV related laws.
- The South African government should adopt the GBV Indicators and commit to allocating resources for periodic GBV studies and dedicated surveys.

Effects

Conclusions

- Women survivors of GBV in Limpopo suffer a range of effects, including physical injury, hospitalisation, loss of work, STI symptoms, economic hardships and stigmatisation.
- GBV also has intergenerational effects because children in abusive homes can be negatively affected.
- Social stigmatisation for women survivors and fear of family fragmentation hampers them from leaving abusive relationships.

Recommendations

- It is essential to strengthen health systems to respond to GBV. Health practitioners need to be trained to provide victim friendly services to survivors. Inclusion of the health sector in the VAW referral system should be mandatory.
- Programmes should prioritise child rehabilitation as a strategy to prevent GBV. There is need for the introduction of school-based GBV prevention initiatives.
- Campaigns should aim to change conservative attitudes towards gender relations and should encourage communities to be more supportive to GBV survivors.

Prevention

Conclusions

- Both women and men are relatively unaware of the GBV campaigns.
- Men in the province seem to have more access to information about campaigns and to participate more in GBV awareness raising events compared to women.

- Television is the most common medium used to access information.
- Initiatives led by local community-based organisations play a vital role in addressing GBV.

Recommendations

- More effective men's mobilisation will require more partnerships between local CBOs like Munna Ndi Nyi and larger men's groups like Sonke.
- GBV campaigns in the province need to be further publicised on television and radio to assume maximum outreach. However, there is need to accelerate efforts to dissemination through other modes, for example community mobilisation and through the print media.

Integrated approaches

Conclusions

- Challenges in the operationalisation of integrated structures and policies include lack of funding for the structures, poor coordination among structure members and poor monitoring and evaluation systems.
- Other issues arising include the inadequacy and ineffectiveness of some of the structures, including the TCCs. Less than half of the cases get referred to courts and the attrition in completed cases leads to case backlogs. This can act as a deterrent to the access of service by survivors.

Recommendations

- More funding and staff allocation is necessary within the various structures that work with GBV victims.
- More training for personnel is also a prerequisite for effective functioning of the integrated approaches.

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GBV AND THE SADC PROTOCOL ON GENDER AND DEVELOPMENT

Response and support

The SADC Protocol provides that by 2015 state parties shall:

- Enact and enforce legislation prohibiting all forms of gender-based violence;
- Ensure that laws on gender-based violence provide for the comprehensive testing, treatment and care of survivors of sexual assault;
- Review and reform their criminal laws and procedures applicable to cases of sexual offences and gender-based violence;
- Enact and adopt specific legislative provisions to prevent human trafficking and provide holistic services to the victims, with the aim of re-integrating them into society;
- Enact legislative provisions, and adopt and implement policies, strategies and programmes which define and prohibit sexual harassment in all spheres, and provide deterrent sanctions for perpetrators of sexual harassment.

Prevention

- The Protocol provides for measures, including legislation, to discourage traditional and cultural practices that exacerbate gender-based violence and to mount public campaigns against these.

Integrated approaches

- The SADC Protocol on Gender and Development calls on states to adopt integrated approaches, including institutional cross sector structures.

The ultimate goal….

- To reduce current levels of gender-based violence by 2015.

Irish Aid
Government of Ireland
Rialtas na hÉireann

gender links for equality and justice

Thohoyandou Victim Empowerment Trust

The study provides analyses of GBV from both the victim and perpetrator points of view, triangulated through an assessment of administrative data. It also gives a holistic picture of the magnitude of VAW. Highlighting the effects of GBV, it instils a sense of urgency in responsible stakeholders to act now in order to curb GBV. The research identifies the repercussions of GBV on women's health and wellbeing.

The solution to addressing the GBV pandemic is primarily about changing the mindsets of both the perpetrators and survivors of violence against women. While the majority of participants in this study stated that both men and women should be treated equally, participants maintain a conservative approach when it comes to gender relations in the domestic sphere.

The report provides valuable insight critical to achieving the SADC Protocol's target of reducing GBV and makes a useful contribution to the ongoing discussion on how to address GBV in the region. It is my recommendation that all relevant stakeholders treat the findings from this research as a call to amplify their strategies as they work with urgency to address GBV, not only in Limpopo, but in South Africa as a whole.

The time is now! Kenako!

Thoko Mpumlwana
Deputy Chairperson of the Commission on Gender Equality,
Commissioner in charge of Limpopo Province and member
of the Gender Links Board

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