The Gender Based Violence Indicators Study

Western Cape Province of South Africa

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Contents

Acknowledgements 3
Acronyms 4
The Management and Research Team 5
Foreword 6
Executive summary 7

Chapter 1: Introduction 19
Chapter 2: Methodology 33
Chapter 3: Extent of GBV 43
Chapter 4: Drivers and patterns 57
Chapter 5: Effects of GBV 75
Chapter 6: Response 89
Chapter 7: Support 109
Chapter 8: Prevention 123
Chapter 9: Integrated approaches 143
Chapter 10: Conclusions and recommendations 157

List of tables

Table I: Extent of GBV in the Western Cape 9
Table II: Socio-economic factors associated with experience and perpetration of IPV 10
Table III: Child abuse as a risk factor of perpetration of IPV 11
Table IV: Personal gender attitudes 12
Table V: Political leadership 13
Table VI: Effects of GBV 14
Table VII: Response and support indicators 15
Table VIII: Prevention indicators 16
Table IX: Conclusion and recommendation 17
Table 1.1: South Africa's progress against different instruments 23
Table 2.1: Project components and tools used to gather data 42
Table 3.1: Demographic, socio-economic and relationship characteristics of participants 45
Table 3.2: Frequency of physical IPV 49
Table 3.3: Frequency of sexual IPV 51
Table 3.4: Frequency of non-partner rape and attempted rape 53
Table 3.5: Extent of reporting GBV in lifetime 54
Table 3.6: Extent of reporting GBV in past 12 months 55
Table 4.1: Socio-demographic factors associated with experience and perpetration of IPV 60
Table 4.2: Disaggregation of experience and perpetration of rape by socio-demographic factors 61
Table 4.3: Alcohol and drug consumption patterns by women and men 61
Table 4.4: Partner alcohol or substance use and experience of IPV in past 12 months 62
Table 4.5: Alcohol or drug use and perpetration of IPV in past 12 months 63
Table 5.1: Association between symptoms of sexually transmitted infections and experience of IPV by women 79
Table 5.2: HIV testing and results 81
Table 5.3: Mental health consequences associated with physical IPV and rape experience in 12 months before the survey 83
Table 5.4: Current running cost for the average TCC 85
Table 5.5: Human resources national costs 85
Table 5.6: National infrastructural victim support services for sexual offences 31 March 2013 86
Table 6.1: FCS units in Western Cape Province 98
Table 6.2: Western Cape sexual offences incidence rates for females 2012 102
Table 7.1: National performance indicators of the VEP 111
Table 7.2: Provincial performance of the VEP programme 112
Table 7.3: Departmental performance indicators 2010-2011 113
Table 7.4: Number of people offered services at Saartjie Baartman Centre (1 September 2011-31 August 2012) 115
Table 7.5: Number of individual counselling sessions per district 119
Table 7.6: Number of rape survivors assisted at four courts in Cape Town (2011/2012) 122
Table 8.1: Transfer payments made by the DSD in 2011/2012 128
Table 8.2: Content of the Life Skills programme upholding gender equality 136
Table 8.3: Training of DV Clerks 140
Table 9.1: Structures in place to ensure public safety 147
Table 9.2: Number of TCCs in Western Cape 149

Table 9.3: Change in number of cases reported at TCCs (nationally) between 2010-11 and 2011-12 150
Table 9.4: Departmental responsibilities within the VEP 153
Table 9.5: Strategic partners within the Western Cape VEP 155

List of figures

Figure 3.1: Any experience of GBV by women or perpetration of GBV by men 46
Figure 3.2: Forms of violence experienced or perpetrated in a lifetime 47
Figure 3.3: Forms of IPV experiences and perpetration in a lifetime 48
Figure 3.4: Acts of emotional abuse in a lifetime 48
Figure 3.5: Acts of physical IPV 49
Figure 3.6: Acts of economic abuse 50
Figure 3.7: Acts of abuse in pregnancy 52
Figure 3.8: Different types of rape experiences and perpetration in a lifetime 52
Figure 3.9: Sexual harassment experiences by women in a lifetime 54
Figure 3.10: Comparison of actual experience prevalence and reported GBV in a lifetime 54
Figure 3.11: Experience or perpetration of GBV in past 12 months 55
Figure 3.12: Comparison of actual experience prevalence and reported physical IPV in past 12 months 55
Figure 4.1: The ecological model of factors associated with VAW 59
Figure 4.2: Experience of childhood abuse by women and men 64
Figure 4.3: Experience of childhood physical abuse in the four provinces 64
Figure 4.4: Experience of childhood sexual abuse in the four provinces 64
Figure 4.5: Childhood trauma factors associated with perpetration of IPV 65
Figure 4.6: Childhood trauma factors and perpetration of non-partner rape 65
Figure 4.7: Women and men's personal perceptions about gender 66
Figure 4.8: Women and men's perceptions of gender attitudes in their communities 66
Figure 4.9: Personal attitudes about sexual entitlement in marriage and legitimacy of violence by women and men 67
Figure 4.10: Women and men's attitudes about sexual entitlement in marriage and legitimacy of violence in the community 67
Figure 4.11: GBV mentions in political discourse 69
Figure 4.12: GBV mentioned as main topic 69
Figure 4.13: GBV speeches by occasion 69
Figure 4.14: Forms of GBV referred to in speeches 70
Figure 4.15: Data sources on extent 70
Figure 4.16: How women and men identify people affected by GBV 71
Figure 4.17: Effects mentioned by speakers 71
Figure 4.18: How often did politicians mention prevention methods? 73
Figure 5.1: Pathways and health effects on IPV 77
Figure 5.2: Women's experience of physical abuse and accompanying effects 77
Figure 5.3: Prevalence of symptoms of and diagnosis of STIs 79
Figure 5.4: Sexual health consequences associated with sexual or physical IPV in prevalence survey 80
Figure 5.5: HIV positive status among survivors and non-survivors 81
Figure 5.6: Mental health symptoms experienced by women 82
Figure 5.7: Mental health consequences associated with current IPV in prevalence survey 82
Figure 5.8: Mental health consequences associated with rape by non-partner in prevalence survey 82
Figure 5.9: Personal and community attitudes about rape by men and women 84
Figure 6.1: Knowledge and awareness of the laws pertaining to the DVA and SOA by women and men 92
Figure 6.2: Sources of information regarding the DVA 93
Figure 6.3: Sources of information regarding the SOA 93
Figure 6.4: National distribution of FCS units 97
Figure 6.5: Compliance rates in selected police stations July-December 2011 100
Figure 6.6: Compliance rates in selected police stations January-March 2012 101
Figure 6.7: Changes in the overall sexual offences in Western Cape between 2011 and 2012 102
Figure 6.8: Number of protection orders granted nationally 2009-2011 105
Figure 6.9: Warrants of arrest issued nationally for breach 2009-2011 105
Figure 6.10: Criminal prosecutions 2010-2011 106
Figure 6.11: Number of registered sexual offenders 106
Figure 7.1: Proportion of women assisted at St Anne's Home April 2010-March 2012 116
Figure 7.2: Number of clients assisted at the courts 120
Figure 7.3: Services at the Rape Crisis Cape Town Trust 2011-2013 121
Figure 7.4: Helpline calls by RCT 2011-2013 121
Figure 7.5: Face-to-face counselling at RCT 2011-2013 121
Figure 7.6: Court support by RCT 2011-2013 121
Figure 8.1: GBV prevention model 125
Figure 8.2: Knowledge and participation in campaigns to end GBV by women and men 132
Figure 8.3: Sources of VAW campaign information 132
Figure 8.4: Slogan most associated with campaigns to end VAW 133
Figure 9.1: Thuthuzela Care Centre model 149
Figure 9.2: Drop in the sexual offences conviction rates 150
Figure 9.3: South Africa's DSD framework: victim-centred approach 153

Acknowledgements

The Gender-Based Violence (GBV) Indicators Project is a regional research study aimed at testing tools to measure and monitor various aspects of violence against women (VAW). The study tests the extent, effect and cost of VAW as well as current efforts to end it in light of the SADC Protocol on Gender and Development's target to halve levels of GBV by 2015. This is a report of a study conducted in Western Cape Province of South Africa in 2011.

Our appreciation goes to the 750 women and 742 men who consented to participate in this study.

GL is especially indebted to the 18 women who shared their personal testimonies or "I" Stories and agreed to have them published in this research. To protect their identity and to avoid any further suffering, the editors have referred to those who gave first-hand accounts using pseudonyms.

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GL Chief Executive Officer (CEO), Colleen Lowe Morna, GL Deputy CEO, Kubi Rama, and former Justice Programme Manager, Loveness Jambaya Nyakujarah, conceptualised and raised funds for the project. Kubi Rama provided oversight and former GBV Indicators Research Manager, Mercilene Machisa, managed the research and stakeholder consultations.

Linda Musariri Chipatiso gathered and analysed the administrative data for the study and contributed in writing some chapters of this report. Violet Nyambo and Machisa analysed data from the different legs of the research and Musariri Chipatiso co-ordinated the writing and editing of all the chapters in this report. Kevin Chiramba assisted in writing and editing some sections of the report.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
AGC	Africa Gender Centre
ANC	African National Congress
BPA	Beijing Platform for Action
CBO	Community Based Organisation
CC&DW	Creative Consulting & Development Works
CEDAW	The Convention on the Elimination of All forms of Discrimination Against Women
CEO	Chief Executive Officer
CGE	Commission for Gender Equality
CSO	Civil Society Organisation
DFID	Department for International Development
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
EA	Enumeration Area
FAMSA	Families South Africa
FCS	Family Violence, Child Protection and Sexual Offences Unit
GBV	Gender-Based Violence
GCIS	Government Communication and Information System
GDP	Gross Domestic Product
GEMSA	Gender and Media Southern Africa Network
GL	Gender Links
GMPS	Gender and Media Progress Study
HIV	Human Immunodeficiency Virus
ICD	Independent Complaints Directorate
IDMT	Inter-Departmental Management Team
IPID	Independent Police Investigative Directorate
IPV	Intimate Partner Violence
IPVPPF	Integrated Provincial Violence Prevention Policy Framework
IVEP	Integrated Victim Empowerment Policy
JCPS	Justice, Crime Prevention and Security Cluster
KZN	KwaZulu-Natal
LMs	Local Municipalities
MRC	Medical Research Council of South Africa
MP	Member of Parliament
NAP	National Action Plan to End Violence Against Women and Children
NCGBV	National Council Against Gender-Based Violence
NCPS	National Crime Prevention Strategy
NGO	Non-Governmental Organisation
NICRO	National Institute for Crime Prevention and Reintegration of Offenders
NOC	National Operations Centre
NPA	National Prosecuting Authority
NPO	Non-Profit Organisation
NRSO	National Register for Sexual Offenders
OMC	One Man Can
NIDA	National Institute on Drug Abuse
PCI	Project Concern International
PDA	Personal Digital Assistant
PEP	Post-Exposure Prophylaxis
PIA	Prevention in Action
PIPV	Perpetrator of Intimate Partner Violence
POs	Protection Orders
PSU	Primary Sampling Unit
PTSD	Post-Traumatic Stress Disorder
RAPCAN	Resources Aimed at the Prevention of Child Abuse and Neglect
RTI	Research Triangle Institute
SADC	Southern African Development Community
SAPS	South African Police Service
SAVE-	Sexual Assault Victim Empowerment
SGVH	Stop Gender Violence Helpline
SOA	Sexual Offences Act
SOC	Sexual Offences Courts
SOCA	Sexual Offences and Community Affairs Unit
STI	Sexually Transmitted Infection
TCCs	Thuthuzela Care Centres
TLAC	Tshwaranang Legal Advocacy Centre
UK	United Kingdom
UN	United Nations
UNECA -	United Nations Economic Commission for Africa
UNIFEM-	United Nations Development Fund for Women
VAW	Violence against women
VEP	Victim Empowerment Programme
VFR	Victim friendly room
VPUU	Violence Prevention through Urban Upgrading
WC	Western Cape
WCG	Western Cape Government
WCNOVAW	Western Cape Network on Violence Against Women
WHO	World Health Organisation

The Management and Research Team



Colleen Lowe Morna is CEO of Gender Links. A South African born in Zimbabwe, Lowe Morna began her career as a journalist specialising in economic and development reporting including as Africa Editor of the New Delhi-based Women's Feature Service. She joined the Commonwealth Secretariat as a senior researcher on the Africa desk in 1991, and later served as Chief Programme Officer of the Commonwealth Observer Mission to South Africa. Lowe Morna subsequently served as founding CEO of the South African Commission on Gender Equality. A trainer, researcher and writer, Lowe Morna has written extensively on gender issues in Southern Africa. Lowe Morna holds a BA degree in International Relations from Princeton University; Masters in Journalism from Columbia University and certificate in executive management from the London Business School. She has received awards from the Woodrow Wilson School of International Relations; the News-women's Club of New York and the Mail and Guardian newspaper in South Africa. In 2007, South Africa's Media Magazine named Lowe Morna runner up in the Media Woman of the Year Award. In 2013, CEO magazine named Lowe Morna the "most influential woman" in South Africa and Africa as a whole in the civil society category. A year later the University of Johannesburg awarded Lowe Morna honorary membership of the Golden Key Association that recognises excellence in academia and public service.



Kubi Rama is GL Deputy Chief Executive 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. Previously, as Deputy Director and Network Manager of GL, 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 campaign, organised a regional media summit and mainstreamed gender as part of training curricula. Prior to joining GL, Rama worked in the Department of Journalism (Durban Institute of Technology) as a senior lecturer.



Linda Musariri Chipatiso joined GL in 2013 as the GBV Indicators Research Officer. As a Hewlett Fellow, Musariri Chipatiso completed her studies towards a Master of Arts degree in Demography and Population Studies from the University of Witwatersrand. She gained significant experience in data management and analysis 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 GL as the Gender Justice & Local Government Facilitator on 1 March 2010. Before joining GL, she worked for the Provincial Government of the Western Cape in the Department of Social Development's head office, working for the Social Capital Formation Directorate. She is also a researcher, facilitator, gender activist and an academic with qualifications in Social Sciences. She holds a Bachelor of Arts 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 and Humanities. She is currently studying towards a Master of Arts degree in Women's & Gender Studies. She also worked as an intern at RAPCAN (Resources Aimed at the Prevention of Child Abuse and Neglect), an NGO in Cape Town, and volunteered at Triangle Project an organisation that focuses on the rights of lesbian, gay, bisexual, transgender and intersex people.



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Foreword


Shaheema Mcleod: Director Saartjie Baartman Centre.

The Western Cape Department government aims to increase safety for all people in the province through effective oversight of policing, making safety everyone's responsibility and optimising safety and security risk management. The big question is are women safe in the Western Cape? Furthermore, is the government providing the right kind of service that is expected of it? Besides the province being the best performing in terms of infrastructure and economic development, it is still marred by high levels of inequalities including gender based violence.

The Western Cape GBV Baseline Study gives an insight on the current state of GBV in the province. The findings should be taken as an awakening by all relevant parties who are working towards improving the status of women as gender violence greatly undermines the pursuit of gender equality. Twenty years into the democracy and still an average woman in the province is not safe. More than a third of women who participated in the study reported that they have experienced GBV at least once in their lifetime. Shockingly, most of the violence is happening behind closed doors - a place called home, where they are supposed to be protected.

Forty-four percent of women interviewed experienced abuse from an intimate partner at least once in their lifetime. Just over one tenth (12%) experienced violence from a partner over the last year. In the streets and public places, women are being harassed and raped. Seven percent of women interviewed experienced rape at the hands of a stranger. Interesting in this study, men are confirming that, yes, they are abusing women. Fifteen percent of men interviewed confirmed they had raped a woman at least once in their lifetime. Thirty-seven percent have abused their partners.

These figures show that GBV has become a pervasive scourge of our modern society. Victims, predominantly women, come from poor to affluent communities across geographic, race, ethnic and economic divides. This shows that GBV cuts across all socio-economic and demographic classes. Every woman is at risk. The role of alcohol abuse in exacerbating gender violence in the Western Cape cannot be overemphasised. Alcohol has been, and remains, a problem in the Western Cape which fuels many social vices that characterise the province. Findings from national household surveys reflect higher prevalence rates for risky drinking relative to the other provinces. Research also shows that alcohol and substance abuse has immensely contributed to dysfunctional families in the Western Cape. Broken families provide a breeding ground for abuse. Child abuse is rampant in the province, thus contributing to the cyclical nature of GBV.

The findings from this study call for a holistic solution to seriously address the problem of GBV. South Africa should be commended for the efforts it is making in responding to GBV: the progressive and comprehensive legislation; the establishment of the National Council against GBV (NCGBV) as co-ordinating board, and other response structures such as the Thuthuzela Care Centres. Currently, the NCGBV is co-ordinating the development of the National Strategic Plan to end GBV, a tool we all believe is very important for the country. At provincial level, we welcome the government initiatives such as the Western Cape Integrated Violence Prevention Frame work of 2013 as well as the Violence Prevention through Urban Upgrading (VPUU). We also have networks such as the Network against GBV that is co-ordinating interventions to address GBV at local levels. However, given the high levels of GBV it is evident that there is need for upscaling our efforts. Are our leaders doing enough to bring the much needed change? Are the policies addressing the patriarchal culture which perpetually reduces women to mere 'properties' owned by their male counterparts? Are enough resources being availed to support survivors of violence?

This report is unique in that it employs a multi-dimensional approach. It seeks to answer all the questions presented here. The attitude survey clearly shows that GBV is deeply entrenched in the patriarchal ideologies that perpetuate the subordination of women. The political discourse shows that the leaders need to upscale their commitment towards the eradication of this epidemic. Thus, the province needs to adopt a multisectoral approach in addressing GBV. The solution needs to bring together all relevant stakeholders in concerted efforts. The solution also needs to address the root causes of GBV as this report has identified them. This includes the reduction of harmful drug and alcohol use as well as eradication of child abuse. Working with men, traditional leaders, religious leaders and the education sector is of paramount importance.

I welcome this study and want to commend Gender Links and partners for the sterling work they are doing. I now call upon all the relevant stakeholders who are in this fight to use the findings from this report.

Executive Summary

Inspired by the SADC Protocol on Gender and Development, which aims to halve GBV by 2015, this study, is the fourth stand-alone, provincially representative and comprehensive community-based research study of its kind. It looked at the prevalence of gender violence in the Western Cape province of South Africa. It measured violence against women (VAW) experience and perpetration, gender attitudes, selected health-related behaviour and exposure to prevention campaigns among women and men in Western Cape. The study also 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; drivers and patterns; effects; responses; support and prevention of VAW.



Children of Joe Slovo informal settlement in Mossel Bay. *Photo: Ntombentsha Mbadlanyana*

Thirty-nine percent of women experienced some form of gender-based violence in their lifetime including intimate partner and non-partner violence. The same (39%) proportion of men had perpetuated GBV in their lifetime.

Most of the violence occurred within intimate relationships and was predominantly emotional, a form of GBV not usually addressed. Forty-four percent of ever partnered women experienced IPV while 37% of ever partnered men reported perpetration of some form of IPV in their lifetime. Forty percent of the women experienced emotional violence while a third of men perpetrated the same form of violence in their lifetime. Women experienced, and men perpetrated, other forms of intimate violence including physical, sexual and economic violence. A quarter of women and 20% of men reported physical IPV experience and perpetration respectively. Thirteen percent of women and 9% of men reported economic IPV experience and perpetration respectively. Thirteen percent of women experienced, and 5% of men perpetrated, sexual IPV.

Thirteen percent of ever pregnant women 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.

More than a tenth (12%) of women experienced and men perpetrated some form of IPV in the 12 months before the survey. Similar to the lifetime prevalence trends, emotional IPV was the most common form reported by both women and men (9%). Six percent of women experienced and 4% of men perpetrated physical IPV in the 12 months before the survey. Six percent and four percent of women experienced economic and sexual IPV respectively. Three percent of men perpetrated economic and sexual IPV in the 12 months before the survey. One percent of women experienced rape by non-partners in their lifetime while 2% of men admitted perpetration of non-partner rape.

Although statistics show that VAW is rife in Western Cape, the majority of women survivors do not report

violence to the police or seek help from health care facilities. Only 1% of women who experienced physical abuse or threats by partners reported the incident to the police, while 2% of the women reported the physical abuse and injuries to medical providers. Generally, the findings revealed an underreporting by women of violence. As such, there is an urgent need to explore factors that hinder women from reporting.

The study has shown significant associations between various individual, relationship, community and societal factors and VAW experience and perpetration. Socio-demographic factors, cultural norms that uphold male dominance and control over women, wife "ownership", sexual entitlement in marriage, men's experience of sexual abuse as children, and alcohol and substance abuse, all exacerbate the incidence of VAW in the Western Cape.

VAW has negative effects on women's health and wellbeing. These effects include physical injury, poor mental health, unplanned pregnancies, stigmatisation, loss of days from work, sexually transmitted infections (STIs) and increased risk to HIV as well as out-of-pocket expenses. Since women constitute a higher proportion of GBV survivors they also bear the higher costs among the survivors.

In response to its high levels of GBV, South Africa has implemented progressive and comprehensive laws, policies and support systems to respond to VAW. Some regional and international instruments adopted by the country include the Convention for the Elimination of Discrimination Against Women (CEDAW), the SADC Declaration on Gender and Development, and the United Nations 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 on Services for Victims of Crime, and the National Policy Guidelines for Victim Empowerment, all of which work towards the elimination of VAW in the country. Despite the legislation, significant proportions of women and men are not aware of these laws. Thirty-eight percent of women and 28% of the men were not aware of the DVA. More than half (60%) of the women and 38% of men were not knowledgeable about the SOA. Women in the province seem to have more access to information about activism campaigns compared to men.

The national Victim Empowerment Programme (VEP) has facilitated the establishment and integration of intersectoral programmes and policies for the support, protection and empowerment of victims of crime and violence, with special focus on women and children. The South African Police Service (SAPS) has estab-lished VEP centres in police stations across the Western Cape Province. There is a shortage of first-stage shelters for abused women. Even fewer second- and third-stage shelters exist, leaving women seeking refuge after first-stage shelter with nowhere to go. The adverse economic conditions faced by many women in the province exacerbate the situation. 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 NCGBV, the 365 Day National Action Plan to End Violence Against Women and Children (NAP), the Integrated Victim Empowerment Policy (IVEP) and the Thuthuzela Care Centres (TCCs). 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. Western Cape government has adopted the Provincial Integrated Violence Prevention Policy Framework which employs the "whole-of-society" approach in preventing violence.

Challenges in the operationalisation of integrated structures and policies include lack of funding for the structures, poor co-ordination 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 access these services. National conviction rates for sexual offences have also decreased.

Table I: Extent of GBV in the Western Cape				
Criteria	**Prevalence of GBV in the survey**			
	Women's experience in a lifetime (%)	Men's perpetration in a lifetime (%)	Women's experience in the past year (%)	Men's perpetration in the past year (%)
Prevalence of GBV	39	39	-	-
Prevalence of IPV	44	37	12	12
Prevalence of emotional IPV	40	30	9	9
Prevalence of physical IPV	25	20	6	4
Prevalence of economic violence	13	9	6	3
Prevalence of sexual violence	13	5	4	3
Prevalence of non-partner rape	7	15	1	2
Prevalence of attempted rape	8	10	1	3
Prevalence of abuse in pregnancy	13	-	-	-
Prevalence of sexual harassment	6	-	-	-
Prevalence of sexual harassment at school	1	-	-	-
Prevalence of sexual harassment at work	5	-	-	-

Table I shows:

- Thirty-nine percent of women experienced some form of GBV, and the same (39%) proportion of men had perpetuated GBV in their lifetime;
- IPV is the most common form of GBV experienced by women, with 44% of women having experienced it in their lifetime and 12% in the 12 months prior to the study;
- Emotional abuse is the most common form of IPV experienced and perpetrated, followed by physical, economic and sexual abuse respectively;
- Six percent of women experienced physical violence in the year prior to the survey;
- Thirteen percent of women experienced some form of abuse during pregnancy;
- Six percent of women had experienced sexual harassment in their lifetime;
- In most indicators, men admitted perpetrating violence less often than women admitted experiencing violence.

Drivers and patterns of GBV

This study used the ecological framework (Heise, 1998) to illustrate risk factors of experience and perpetration of IPV. It explored individual, community and societal factors associated with experience and perpetration.



Individual factors

Table II: Socio-economic factors associated with experience and perpetration of IPV								
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	44.7	0.19	41.4	0.26	17.6	0.002	19.9	0.0002
30-44	46.9		36.9		15.3		10.8	
45+	38.7		31.4		4.6		3.5	
Level of education								
High school incomplete and lower	47.6	0.17	42.4	0.02	13.1	0.47	13.8	0.31
High school complete and over	39.9		32.2		10.7		10.1	
Worked in past 12 months								
No	43.2	0.87	39.1	0.39	10.4	0.17	13.1	0.21
Yes	43.9		35.0		13.6		10.5	

Table II shows:

- Age, level of education and employment status were not associated with IPV among women in GBV experiences in lifetime. This implies that all women remain vulnerable to IPV;
- There was a significant difference in men's perpetration of IPV according to age and in the 12 months prior to the study;
- A statistically significant proportion ($p<0.05$) of men who did not complete high school, perpetrated IPV in their lifetime compared to men who did complete high school.

Rape

There was no statistical difference in the proportion of women raped by a non-partner according to age, level of education and employment status both in lifetime experiences and in the 12 months prior to the survey;
A significantly higher proportion of men who worked 12 months prior the survey admitted raping a non-partner ($p=0.02$).

Childhood abuse

The study explored whether experience of childhood abuse is associated with IPV and rape perpetration by men. The childhood experiences of both women and men who took part in the study showed that more men than women experienced the various forms childhood abuse. A higher proportion of men (80%) and about half (49%) of women experienced physical abuse in childhood.



Table III: Childhood abuse as a risk factor of perpetration of IPV				
Factors	**IPV**		**Non-partner rape**	
	% men perpetrating	p value	% men perpetrating	p value
Childhood physical abuse				
No	22.0	0.003	7.3	0.02
Yes	40.0		17.4	
Childhood sexual abuse				
No	31.0	0.0001	8.1	0.000
Yes	55.0		41.0	
Childhood neglect				
No	27.0	0.000	10.4	0.01
Yes	45.0		19.2	

Table III shows:

- All forms of childhood physical abuse were significantly associated with perpetration of both IPV and non-partner rape ($p<0.05$);
- Two fifths (40%) of men who had been physically abused as children reported perpetrating IPV whereas 22% of men who did not experience physical abuse committed IPV;
- Slightly less than half of men who had been victims of childhood neglect (45%) committed IPV compared to those who had not suffered neglect (27%);
- A higher proportion (55%) of male survivors of childhood sexual abuse perpetrated non-partner rape compared to non-survivors;
- Nearly a fifth (19%) of survivors of childhood neglect perpetrated non-partner rape while 10% of non-sufferers of child neglect admitted the same offense;
- Forty-one percent of male survivors of childhood sexual abuse committed non-partner rape whereas 8% of non-sufferers of childhood sexual abuse still committed non-partner rape.

Alcohol and drug use

Alcohol and drug use was associated with IPV perpetration in the 12 months preceding the survey; and About one fifth (19%) of male drug users and 8% of non-drug users perpetrated IPV in the 12 months prior to the survey.

Relationship factors

Generally, the attitudes that support gendered masculinity and patriarchy increased the risk of VAW.

Community factors

Table IV: Personal gender attitudes		
	Women strongly agree %	Men strongly agree %
Gender relations		
I think a woman should obey her husband	70	90
I think people should be treated the same whether they are male or female	80	94
I think that a man should have the final say in all family matters	25	67
I think a woman needs her husband's permission to do paid work.	13	25
I think that there is nothing a woman can do if her husband wants to have girlfriends	13	14

	Women strongly agree %	Men strongly agree %
Sexual entitlement		
I think it is possible for a woman to be raped by her husband	48	64
I think that if a man has paid lobola for his wife, he owns her	8	42
I think that a woman cannot refuse to have sex with her husband.	17	39
I think that if a wife does something wrong her husband has the right to punish her	8	27
I think that if a man has paid lobola for his wife, she must have sex when he wants it	6	34

Table IV shows:

- High proportions of women (70%) and men (90%) agreed that a woman should obey her husband;
- High proportions of women (80%) and men (94%) felt that people should be treated the same despite their gender;
- Greater proportions of men than women thought that a husband has sexual entitlement;
- Eight percent of women and 42% of men agreed that if a man paid lobola, he owns his wife;
- Eight percent of women and 27% men believed a husband has the right to punish his wife if she does something wrong.

Societal factors

Political environment

Table V: Political leadership	
Criteria	**%**
Percentage of GBV speeches by politicians that mention GBV (April 2010-March 2011)	7
Percentage of GBV speeches by politicians that refer to GBV as main topic	6
Percentage of GBV speeches by politicians that refer to physical abuse	51
Percentage of GBV speeches by politicians that refer to sexual offences	43
Percentage of GBV speeches by politicians that refer to domestic violence	31.4
Percentage of GBV speeches by politicians that refer to economic abuse	22.9
Percentage of GBV speeches by politicians that refer to femicide	11.1
Percentage of GBV speeches by politicians that refer to the link between GBV and HIV	10.5
Percentage of GBV speeches by politicians that refer to emotional abuse	5.9

Table V shows:

- Of the 2 238 speeches issued from April 2010 to March 2011, only 7% referred to GBV;
- The most mentioned form of GBV was physical abuse (51%), while the least discussed was emotional abuse (6%);
- Political leaders mentioned domestic violence in 31% of the speeches referring to GBV;
- Eleven percent of the speeches referring to GBV addressed the link between HIV and GBV.

Effects of GBV

Table VI: Effects of GBV	
Criteria	**% women**
Physical injury	
Percentage of physically abused women who sustained injuries	28
Percentage of physically injured women who spent days in bed because of injuries	59
Percentage of physically injured women who missed work as a result of injuries	45
Sexual and reproductive health	
Percentage of women who had been sexually abused by intimate partners and diagnosed with an STI	47
Percentage of women who had been physically abused by intimate partners and diagnosed with an STI	32
Percentage of women who had been raped by non-partners and diagnosed with an STI	41
Percentage of women who had been physically or sexually abused by intimate partners and tested HIV positive	13
Percentage of women who had been raped by non-partners and tested HIV positive	29
Poor mental health	
Percentage of women who had been abused by intimate partner and suffered depression	54
Percentage of women who had been raped by non-partner and suffered depression	41
Percentage of women who had been abused by intimate partners and attempted suicide	46
Percentage of women who had been raped by non-partners and attempted suicide	29

Table VI shows:

Physical injury

- Twenty-eight percent of women in the survey who had experienced physical abuse sustained injuries;
- A significantly high proportion (59%) of the women who experienced physical abuse sustained serious injuries and had been bedridden.

Reproductive health effects

- Almost half of the women (47%) who had suffered sexual abuse from an intimate partner had contracted an STI;
- Thirty-two percent of women who had experienced physical abuse reported having been diagnosed with STIs;
- Forty-one percent of women who had been raped by a non-partner in their lifetime had been diagnosed with an STI;
- Thirteen percent of women who experienced physical or sexual abuse by an intimate partner tested HIV positive.

Mental health effects

- A significant proportion (54%) of IPV survivors and two fifths (41%) of non-partner rape survivors had suffered from depression;
- Forty-six percent of IPV survivors attempted suicide;
- Nearly a third (29%) of women raped by non-partners attempted suicide.

Costs of GBV

Due to bureaucratic constraints and poor recording systems, it is difficult to access data on the accurate amounts of money spent on GBV. Data derived from the Department of Justice and Constitutional Development shows that the estimated cost of running a Thuthuzela Care Centre in the Western Cape is R4 089 312 per annum.

Response and support

Table VII: Response and support indicators

Criteria	% women	% men
Awareness of legislation		
Proportion of participants aware of the Domestic Violence Act	62	72
Proportion of participants aware of the Sexual Offences Act	40	62
Proportion of participants aware of protection orders (POs)	78	75
South African Police Service (SAPS)		
Number of rape cases recorded by SAPS in 2011/2012	5 969	
Number of sexual assault cases recorded by SAPS 2011/2012	2 005	
Number of sexual offences detected by police 2011/2012	236	
Number of other contact sexual crimes recorded by SAPS 2011/2012	513	
Number of attempted sexual offences recorded by SAPS 2011/2012	410	
Number of interim protection orders granted in 2011	217 987	
Number of final protection orders granted in 2011	87 711	
Number of Family Violence, Child Protection and Sexual Offences Units (FCSs)	25	
Number of Victim Friendly Rooms (VFCs)	150	
Number of final protection orders granted in 2011	87 711	
Number of interim protection orders in 2011	217 987	
Shelters and counselling services		
Number of new cases received at Saartjie Baartman Centre	739	
Number of new cases received at St Anne's Home and Place of Safety 2011-2012	61	

Table VII shows:

Awareness of laws

- More men (72%) than women (62%) are aware of the Domestic Violence Act;
- About two fifths (40%) women and 62% men interviewed knew about the Sexual Offences Act;
- Seventy-eight percent women and 75% of men had heard about protection orders.

South African Police Services

- The SAPS recorded 5 969 rape cases, 2 005 sexual assault cases and 410 attempted sexual assault cases in 2011/2012.
- The SAPS created 25 FCS units in the Western Cape. These offer specialised services to deal with domestic violence at police stations.
- About 150 Victim Friendly Rooms exist in the Western Cape. The VFCs offer private and comfortable environments for survivors to be informed about their rights following a case of GBV.
- There was a significant variation in interim POs and final POs granted in 2011.
- For the year 2011, police granted 217 987 interim POs and 87 711 final POs.

Prevention

Table VIII: Prevention indicators		
Criteria	**% women**	**% men**
Proportion of participants who had heard of the 16 Days of Activism campaign in the 12 months prior to the survey	83	78
Proportion of participants who had heard of the 365 Days campaign in the 12 months prior to the survey	83	54
Proportion of participants who had ever participated in a march or event in protest against GBV	27	22
Proportion of participants who had accessed information about GBV from a radio programme	32	49
Proportion of participants who had accessed information about GBV from a television programme	38	16
Proportion of participants who had accessed information about GBV from newspapers	10	25

Table VIII shows:

- A higher proportion (83%) of women compared with 78% of men had heard about the 16 Days of Activism campaign in the 12 months prior to the survey;
- Eighty-three percent of women and 54% of men had heard about the 365 Days campaign;
- Less than a third (27%) of women and 18% of men had participated in a march or event in protest against GBV;
- Thirty-eight percent of women and 16% of men had received information about GBV from a television programme;
- More men (25%) than women (10%) received information about GBV from a newspaper;
- Compared to other provinces studied, women and men in the Western Cape (and women more so than men) are more aware of campaigns and legislation to protect women and children.

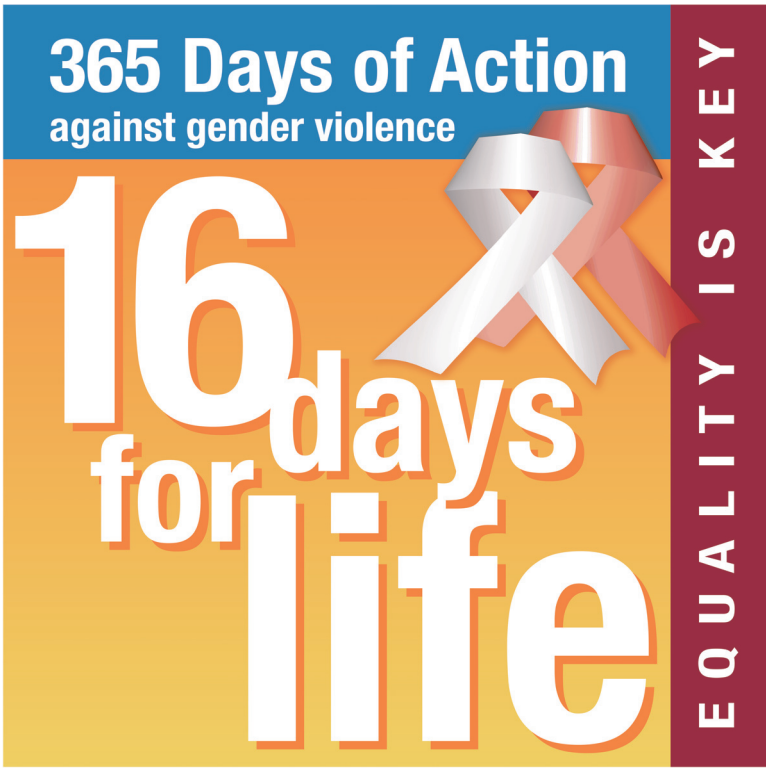


Table IX: Conclusion and recommendation	
Conclusions	**Recommendations**
Extent	
Western Cape like KwaZulu-Natal (KZN), Limpopo and Gauteng exhibits high prevalence rates of GBV. Emotional IPV is the highest form of GBV experienced by women and perpetrated by men both in their lifetime and in the 12 months before the survey.	There is a need to focus on prevention strategies that seek to address the root causes of violence in both the public and private domains. There is a need to educate the community to treat violence against women, especially IPV, as a major social problem. The community and individuals need vigorous encouragement to change the attitudes that promote a culture of silence. There is also need for stiffer penalties for perpetrators of GBV.
The study shows high levels of underreporting of GBV in the province. The majority of women who experienced IPV or non-partner violence are less likely to report abuse to the police and health care providers.	There is a need to explore further the factors that promote underreporting of violence. Appropriate interventions such as improvements in service provision by the police and health care providers are necessary. These should emphasise both quality as well as quantity. Mechanisms aimed at reducing the danger of community stigmatisation are essential. There is need to empower women to demand their rights and be able to speak out about their experiences of abuse in the public and private domains.
Drivers and patterns	
Perpetration of IPV in a lifetime is inversely associated with education. Perpetration of IPV in the past 12 months significantly decreased with an increase in age. For women, experience of IPV in their lifetime was not significantly associated with age, education and employment implying all women are at an equal risk regardless of their socio-demographic factors.	It is important to promote awareness training especially to sensitise and educate young men against GBV. There is great need to eradicate patriarchal gender attitudes that promote inequality and the subordination of women by men in intimate relationships.
Experience of childhood abuse influences the perpetration of IPV by men. Similarly, childhood neglect and sexual abuse increase the risk of men perpetrating non-partner rape.	There is need to develop strict control measures particularly in the area of corporal punishment which is taking place illegally behind closed doors in homes and in schools. It is critical to prevent all forms of child abuse. There is need for abuse screening in schools as well as to provide rehabilitation services to abused children.

Conclusions	Recommendations
Alcohol and drug abuse is rampant in the province and this triggers violence thereby increasing the risk of IPV perpetration. The government passed the Western Cape Liquor Act of 2009 which came into effect from April 2012 which regulates liquor outlets and aims to limit access to alcohol in residential areas.	There is need to intensify health promotions that discourage the unwarranted use of alcohol. There is need to revise the current legal drinking age and to introduce a minimum liquor purchasing age. There is need for government to take on alcohol abuse as a national priority. Government can do this by introducing and sustaining more severe penalties for excessive drinking.
There are relatively few mentions of GBV by government in public discourse. Furthermore, the speeches imply that government does not sufficiently understand the problems associated with GBV in the country.	There is need for politicians to champion the fight against GBV. It is crucial that politicians make regular public pronouncements informed by an understanding of the forms and nature of violence.
Effects	
Evidence shows that women who experience IPV are prone to physical injury, poor mental health and increased risk of HIV and STIs. GBV ultimately results in death or disability.	There is a need for the health sector to be responsive to current World Health Organisation clinical and policy guidelines on IPV and sexual violence. Also crucial is the need for prompt screening of GBV survivors to ensure improved access to appropriate medical care. Government should take the lead in prioritising mental health by providing adequate funding, appropriate infrastructure and human capital to psychiatric and mental health services. There is need for a holistic approach that engages the media, health services, policy makers and social services in responding to, as well as preventing, GBV.
Response and support	
Government has taken significant strides by establishing structures that seek to focus on the victims of GBV. The major departments mandated to assist survivors of violence are the police, justice, social services and health. Evidence shows that the provision of shelters and economic empowerment are ways to improve survivorship of GBV. There are few shelters in the Western Cape that offer support to survivors of GBV.	There is need for constant monitoring and evaluation of the policies relating to violence to ensure the adoption of effective prevention and response mechanisms in the province. It is important for government to increase funding to existing shelters, victim friendly rooms (VFRs), and other GBV-related initiatives in the Western Cape, including establishing new places of safety.

Conclusions	Recommendations
Prevention	
Factors that increase the risk of violence are multifaceted in nature. These often include the need to perpetuate conservative individual and community attitudes on gender equality, alcohol and drug abuse, child abuse and socio-economic factors such as age and education.	There is need for government and civil society to undertake a paradigm shift from a responsive perspective to a more proactive shift in addressing all factors influencing violence in the society. There is need to place more emphasis on mobilising communities especially in rural areas, to challenge gendered ideas of masculinity. It is critical to implement secondary and tertiary interventions that prevent recurring acts of perpetration.
It is commendable that in the Western Cape, the majority of women were aware of prevention campaigns and laws and that they proved to be more knowledgeable compared to men. In the other provinces, men were more knowledgeable than women.	There is need to strengthen the strategies which encourage women to participate in the campaigns relating to GBV. It is critical to sensitise men so that they also participate in campaigns and marches, and not only to know the laws that protect women but to embrace and uphold them in order to prevent further perpetration of VAW.
Strong and sustained political will and commitment is critical in the implementation of violence prevention strategies. The government allocated about R16 million towards GBV in 2013/2014. Western Cape government developed the provincial integrated violence prevention policy framework which employs the "whole-of-society" approach in preventing violence.	It is critical for government to avail sufficient resources for ending GBV.
Integrated approaches	
The government of South Africa has done well in coming up with policies and structures that seek to protect women compared to other countries in the region. It has made significant strides in drawing up plans such as the 365 Day NAP, the National Council against GBV and the Integrated Victim Empowerment Policy among others. Nevertheless, these plans fall short when it comes to full implementation because of lack of adequate funding, poor planning, lack of coordination, accountability and capacity, and confusion as to demarcation of responsibilities among stakeholders.	There is need to adequately fund the implementation of the action plans and other initiatives related to ending GBV. There is need to use best practices in educating, and increasing capacity of the personnel involved in the planning, coordination and successful implementation of action plans on GBV. It is critical for government to develop a dedicated monitoring and evaluation framework that is utilised by organising committees of the various action plans.

CHAPTER 1
INTRODUCTION



Pieter Pepler (left), George Municipality GFP and Executive Mayor of Eden district, Councillor Wessie van der Westhuizen. *Photo by Ntombentsha Mbadlanyana*

Key facts

- Violence against women is one of the most common serious human rights violations in the SADC region, especially in South Africa.
- South Africa adopted the Protocol on Gender and Development which, among other aims, aims to halve GBV by 2015 and achieve gender equality and equity.
- The Western Cape Indicators Study sought to provide reliable baseline data, targets and indicators for measuring the progress of GBV in an arena where underreporting of violence is common.
- The study seeks to document the prevalence and perpetuation of GBV using a representative sample from Western Cape Province.



"My name is Berucha. My story began when I was 16 years old. At that time, I left school at an early age. Things were not right and we were struggling financially. I went to look for a job. I then moved to Plettenberg Bay with my sister and her husband. I found a job at SPAR Plettenberg Bay. At that time, I did not have money for taxi fare or anything to eat.

We stayed there for a month and then they had to move out. They left me in a house with no food and I didn't know anyone to help pay the rent or assist me with anything.

I stayed in a house without power or water because the people where I rented said I first had to pay before they would put on the power or water. That's how I met a friend who promised to introduce me to someone who could help me financially. One day when I came from work, I saw this man standing and waiting for me. We talked and he seemed like a nice guy though I only liked him as a friend. I never knew that he wanted to be intimate with me. He started giving me money and spoiled me with gifts. I accepted his money and gifts because I was desperate, alone and in need. I then discovered that he was into witchcraft. I started sleeping with him because I was scared. He forced me to sleep with him for money. This went on for whole year. After that I couldn't take it anymore so I ran away to my mother's house. I was at home for a month trying to forget about the whole thing that had happened to me, but I didn't tell my mother. I was ashamed. One Sunday afternoon while I was sitting and watching TV, someone knocked at the door. It was this man again, and my mother invited him in.

He said he was a friend of mine. I was shocked and I started crying. My mother was also shocked and she asked me what the matter was. I didn't say anything to her because I was scared. I told this man that he must leave me alone or I will call the police. He said he will tell them I had stolen from him. He started phoning me and threatened me over the phone. He also sent me letters and told me that he knew my every move. I was in a state of killing myself. I was so scared to come out of the house.

He told me that I will never lead a happy life. Since that time, I met my children's father and later we separated. I met someone else and we also broke up. Now I am in an abusive relationship. Up to today I am in still in fear. My mother is still living in Plettenberg Bay but I am scared of going to my mother's place because of that man. He threatened to kill me. However, I know that one day God will end this fear. My message to all readers is that I am a strong woman. Although still scared, I face the challenges that come my way with hope in my heart. I have to be a role model to my children. To all women and victims out there, never give up. What we are going through is not a permanent situation."

This story typifies the ordeal that several women go through every day of their lives. Some women, like Berucha, live in perpetual fear of their male counterparts. They find themselves trapped in situations where they are at the mercy of their partners. Due to structural poverty, they are forced to live in these horrible situations. In certain cases such as Berucha's, their whole lives are marked with abuse from different men and at different stages. It is stories like this one that underscore the importance of this research.

This report outlines the background, methods and findings of the GBV Baseline study in the Western Cape province of South Africa conducted by GL in 2011. More specifically, this opening chapter outlines the regional background and rationale to the GBV Baseline study in Western Cape, its unique features, country context and previous related research.

Background and rationale

Violence against women 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 violations, 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 the last 12 years, using the 16 Days of Activism Against Gender Violence 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 (NAP) 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, rendering administrative data an unreliable source of information.

In August 2008, SADC heads of state adopted the Protocol on Gender and Development that, inter alia, aims to halve gender violence by 2015. The question that then arises is how governments will know if they are achieving this target if we do not know the starting point. To measure the efficacy of both government and civil society programmes, there is need to have baseline data on the extent and effects of GBV, as well as the manner in which governments and civil support organisations respond to GBV. This underpins the innovative GBV Indicators Project conducted in South Africa, Botswana, Mauritius, Zimbabwe, Zambia and Lesotho 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 (e.g. gender, justice, health, police, and the 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, through administrative data collection and situational analysis, that there are gaps in the data on GBV collected by different countries. Some countries do not even have recording systems for any aspect of GBV. Laws in the different 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 despite the fact that most countries are in unanimous agreement that GBV is a gross violation of human dignity, and have made demonstrable strides in combatting its existence, mainly through ratifications such as the SADC Protocol on Gender and Development.

The work of developing a set of indicators to measure GBV includes the United Nations Development Fund for Women (UNIFEM) funded expert group think tank meeting that took place in July 2008. Sixteen representatives from government, research organisations, South African and regional NGOs focusing on gender and gender violence issues participated. This meeting sought conceptual clarity on what was required, as well as get buy-in from key stakeholders on developing a composite set of indicators to measure gender violence that are methodologically solid, pre-tested, and eventually applied across the region.

The think tank aimed to determine the following:

- The indicators that can 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;
- Response and support interventions as measured by the multi stakeholder NAP to End Gender Violence (that are in turn based on the SADC Addendum and draft Protocol on Gender and Development);
- Prevention interventions that underscore the importance of a paradigm shift towards prevention rather than simply response mechanisms.

Key conceptual decisions taken at the meeting include:

- The need to incorporate GBV as experienced by both women and men, and mostly perpetrated by men with a greater emphasis on the fact that women are most affected by GBV;
- To interrogate existing administrative data much more closely;
- To use prevalence studies to determine the extent of underreporting and rarely reported types of abuse such as emotional and economic abuse;



A 2012 think tank meeting helped determine key indicators that can be used to measure the extent of GBV in Southern Africa. *Photo: Daud Kayisi*

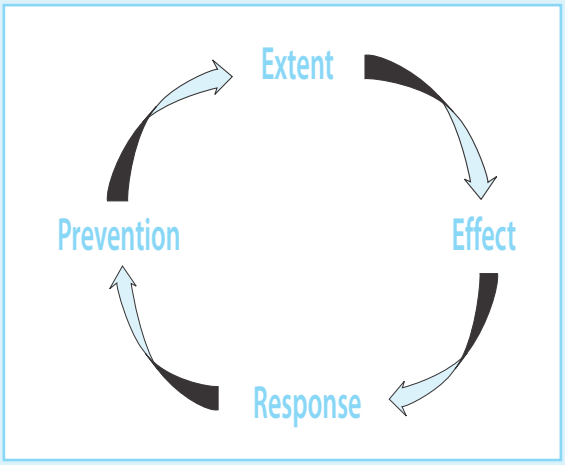
- To combine prevalence and attitude studies;.
- To facilitate more in-depth interrogation of data, for example on whether there are links between being a survivor/perpetrator and various kinds of attitude/behaviour.

Overall, the team emphasised the need to test a draft set of indicators in a pilot project at local level before these were cascaded nationally and regionally. This study would gradually build support and buy-in for a comprehensive set of indicators that provide 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.



Country context



South Africa is renowned for having high levels of crime that stem from a history of interpersonal violence linked to conflict and political struggle[1]. Violence and injury are the second leading cause of death and reduction in quality of life, also known as lost disability-adjusted life years in South Africa[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 gender-based violence, including the 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 overall objectives of the Protocol are to provide for the empowerment of 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.

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].	1. Establishment of mechanisms to address the needs of survivors, including one-stop centres with counsellors, police and legal officers.
	2. Use "due diligence" to prevent, prosecute and punish perpetrators who commit violence against women.	2. A 365 Day NAP is in place to address GBV.
	3. Collect data on violence against women.	3. A progressive legal framework that ensures the protection of women's rights is in place.
	4. Sensitise members of the criminal justice system.	4. Police and prosecutors are undergoing training to address issues of sexual violence.

1 www.statssa.gov.za
2 Seedat et al 2009.
3 Commission on Human Rights, 1996.

Instrument	State responsibility	Progress made
Beijing Declaration and Platform For Action - (1995)	1. Enact legislation on preventing and addressing issues of violence against women and girls.	a) Domestic Violence Act, 1998 (Act 116 of 1998); b) Sexual Offences Act, 1957 (Act 23 of 1957); c) Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007 (Act 32 of 2007); d) Employment Equity Act (No 55 of 1998); e) Protection from Sexual Harassment Act , 2013.
	2. Put in place strategies to address survivors of violence, as well as strategies with punitive measures against perpetrators of violence against women.	a) The Anti-Rape Strategy (prevention, reaction and support) developed by an interdepartmental management team as an integrated response to 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; f) Local and community-based programmes (community policing, neighbourhood watches).
SADC Gender and Development Protocol 2008	1. Enact and enforce prohibitive legislation.	a) Domestic Violence Act, 1998 (Act 116 of 1998); b) Sexual Offences Act, 1957 (Act 23 of 1957); c) Criminal Law (Sexual Offences and Related Matters Amendment Act, 2007); d) Employment Equity Act (Act No 55 of 1998); e) Protection from Sexual Harassment Act of 2013.
	2. Eradicate social, economic, cultural and political practices and religious beliefs that legitimise and exacerbate the persistence and tolerance of gender-based violence.	Communication, education and awareness programmes commissioned.
	3. Adopt integrated approaches, including institutional cross-sector structures, with the aim of reducing current levels of violence by 50%.	Inter-Departmental Management Team (IDMT) put in place at government level to coordinate an integrated response to violence against women.
	4. Ensure implementation, monitoring and evaluation of the abovementioned efforts.	Although systems have been put in place, there is need for more vigilant data collection and management. There is need for a comprehensive set of indicators to evaluate progress. In conducting this research, GL is testing a set of indicators for use as baseline and for monitoring GBV programmes.

The GBV Baseline study implemented by GL focuses mainly on achieving Article 25 of the SADC Protocol on Gender and Development relating to adopting integrated approaches to reduce levels of gender-based violence 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

An effective legal framework is a precursor for ending violence against women. It demonstrates a government's commitment to upholding citizens' human rights. Further to the commitment of heads of states, government departmental efforts are also important in ending gender violence.

South Africa has enacted protective laws to address issues of GBV. The Domestic Violence Act No. 116 of 1998 came into effect in 1999. The Act seeks to protect women, men and children against violence, regardless of their sexual orientation. A study, conducted to monitor the impact of the DVA on the lives of women from 1999 to 2003, found the 40% increase in protection orders issued after the new legislation was enacted could be accounted for by those taken 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 as from 16 December 2007. The Act expanded the definition of rape to encompass the rape of men and use of any object in sexually assaulting another person.

The Protection from Sexual Harassment Act 17 of 2011 came into operation in 2013. It seeks to protect both women and men from sexual harassment in both public and private domains. It offers protection orders to the victim of sexual harassment.

Integrated Approaches

Prior to the SADC Gender and Development Protocol, South Africa had made progress through the development of a 365 Day 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 (NPA)'s Sexual Offences and Community Affairs (SOCA) Unit. The plan was an expansion of the efforts observed in the 16 Days of Activism Against Violence Against Women and came about through multisectoral partnerships between government and civil society organisations. The key focal areas of implementation include the following: legal, social, economic, cultural, political services; awareness, education and training; integrated approaches and budgetary allocations.[4]

National Council Against Gender Based Violence (National GBV Council)

Deputy President of the Republic of South Africa, Mr Kgalema Motlanthe, inaugurated the national GBV Council on the 10th of December, 2012. Composition of the council comprises departments, provinces, civil society, NGOs, faith-based organisations, traditional leadership and government agencies. The role of the council is to elevate the multisectoral intervention approach to a strategic level and monitor the implementation of all programmes dealing with GBV in the country, including the 365 Day Action Plan. The National GBV Council advises the Ministry and or Deputy President and Deputy Chairperson of the Council, in fulfilling their leadership responsibilities relating to the national response against GBV.

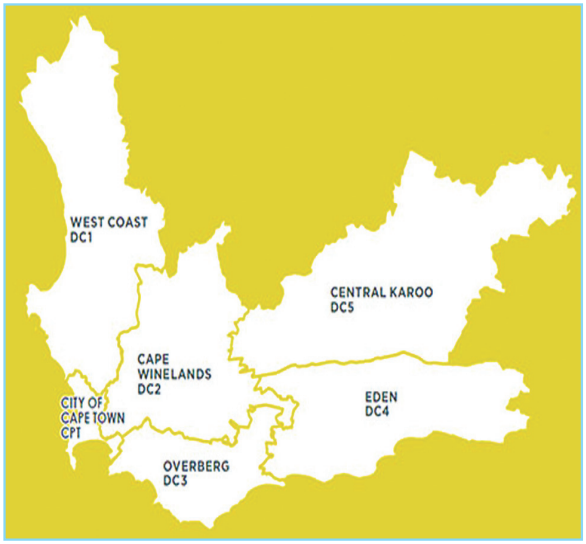
Provincial context

The Western Cape is located on the southern tip of the African continent between the Indian and Atlantic Oceans. The Northern Cape and Eastern Cape provinces border it. The Western Cape's natural beauty makes the province one of the world's greatest tourist attractions.

It covers an area of 129 462km^2 and has a population of approximately 5 822 734. It is the fourth largest province in South Africa by surface area and also ranks fourth in population. It is divided into one metro-

[4] Gender Links, VAW Baseline Studies, 2012-2013.

politan municipality (City of Cape Town) and five district municipalities, which are further subdivided into 24 local municipalities. In comparison to other provinces, the Western Cape seems to be the best performing in terms of infrastructure and economic development. The province has a well-established industrial and business base and the lowest unemployment rate in the country. Sectors such as finance, real estate, ICT, retail and tourism show substantial growth, and are the main contributors to the regional economy. Many of South Africa's major insurance companies and banks base themselves in the Western Cape. The majority of the country's petroleum companies and the largest segment of the printing and publishing industry are located in Cape Town.



Addressing violence in Western Cape

Western Cape Government (WCG) Integrated Provincial Violence Prevention Policy Framework August, 2013

The Framework recommends the adoption of a comprehensive intersectoral approach that balances short-term, evidence-based interventions focused on reducing the availability and harmful use of alcohol, with longer-term interventions that require the state and all citizens to take active responsibility in addressing, more holistically, the complex social norms that support violence. In efforts to prevent GBV, the WCG has moved from the traditional law enforcement approach to the whole-of-society approach that focuses on the root causes of violence and the situational contexts of violence, as the main response to violence. This approach draws on the resources, capabilities and collective agency of every single citizen - working in partnership with one another, and the state - to demotivate potentially violent offenders and remove opportunities for them to engage in acts of violence. The whole-of-society approach, then, dovetails neatly with the proactive, preventative public health approach.[5]

Violence Prevention through Urban Upgrading Project

The Violence Prevention through Urban Upgrading (VPUU) project is a holistic approach to urban upgrading that is unique in the Cape Town context in the way that it integrated all forms of development, not only the physical upgrading of urban spaces. This innovative project initiated in 2006 in partnership with the German Government, through the German Development Bank. VPUU aims to reduce crime and increase safety levels, to upgrade neighbourhoods, improve social standards and to introduce sustainable community projects to empower local residents. The project has so far focused on the improvement of areas in the Khayelitsha "suburbs" of Harare, Kuyasa, Site C/TR section and Site B to create safe areas for thousands of people. VPUU has a set of safety principles that are guidelines in the upgrading/development process, and are in line with those of Crime Prevention through Environmental Design.[6]

Previous Research

GBV Indicators Study

The current study is the fourth series of the GBV indicators studies undertaken in South Africa. The first study, War at Home - Gauteng, launched in 2012. Then followed the Limpopo GBV Indicators Study in

[5] http://www.westerncape.gov.za/text/2013/September/violence-prevention-cabinet-policy-final.pdf
[6] https://www.capetown.gov.za/en/MetroPolice2/Pages/Violence-prevention.aspx

2013, and the KwaZulu-Natal GBV Indicators Study in 2014. All the previous studies employed the same methodology tools as used for this study. The GBV Indicators Study seeks to understand, better, the extent, effects, responses and prevention of GBV within the various contexts. Below are the key findings from Gauteng, Limpopo and KZN.

War at Home - Gauteng, Gender Links & MRC, 2012

The study was the first comprehensive community-based research study on the prevalence of VAW in the Gauteng province and South Africa. More than half of women in Gauteng (51%) had experienced some form of violence (emotional, economic, physical or sexual) in their lifetime and 78% of men in the province admitted 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 were 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.

GBV Indicators Study in Limpopo, Gender Links, 2013

According to the study in Limpopo, more than two thirds of women (77%) had experienced some form of gender-based violence in their lifetime including partner and non-partner violence. About half of men (48%) admitted to perpetrating VAW at least once in their lifetime.

Most of the violence occurred within intimate relationships and was 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 in their lifetime. 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 was the most common form reported by women (10%). 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 did not report violence to the police or seek help, and many women did not seek help from health care facilities. Only one in eight women physically abused by intimate partners reported it to the police. A lower proportion of women - one in 10 - sought medical attention after physical abuse. 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 (0.8%) who had been raped reported it to police. About one in every five women (1%) who had been raped sought medical attention. This finding is consistent with studies conducted in Gauteng and other SADC countries where research shows similar under-reporting of non-partner rape and physical IPV.

GBV Indicators Study in KwaZulu-Natal, Gender Links, 2013

The KZN GBV Indicators Study showed that 37% of women in KZN have experienced some form of gender-based violence in their lifetime, including partner and non-partner violence. Forty three percent of men admitted to perpetrating some form of violence against women. About a third (31%) of a provincially representative sample of women experienced, while 44% of men (also from a representative sample) perpetrated, some form of IPV in their lifetime. The predominant form of violence within intimate relationships was psychological with a quarter (25%) of women experiencing it.

Women also reported experience of other forms of GBV, including non-partner rape, sexual harassment and abuse during pregnancy. Four percent of women polled had experienced rape by non-partners while 12% of men admitted raping a non-partner in their lifetime. As was seen in Limpopo and Gauteng, despite the high levels of GBV in KZN communities, the majority of female victims did not report violence to police, seek medical attention or legal recourse. Five

percent of women who had suffered physical abuse reported it to police, while just 4% reported the incident to medical providers. Of those women raped by a non-partner, less than 1% reported it to police or healthcare providers. This underreporting shows that violence is still seen as a private matter, an issue that will be explained in further detail in this report.

Barriers to reporting violence have been located at the individual level as well as within community spheres, where violence is normalised and societal mores remain patriarchal. Forty three percent of men and 36% of women agreed that a man could use violence as a punishment to a wife for wrongdoing. Survivors of rape face stigmatisation with more than half of the men (56%) and nearly a quarter (23%) of women saying rape survivors can often be seen as responsible because they are promiscuous. More than a quarter of men (27%) and 17% of women blamed the rape survivor for the rape. In addition to the negative community responses to victims of domestic violence and rape, other barriers identified included the inaccessibility of services and the possible risk of secondary victimisation by service providers.

Coming to the fore in these studies is the gravity of GBV in the different contexts. This serves to show that GBV goes beyond geographical or cultural borders. All relevant stakeholders should use the findings from these studies as well as the current to inform policies and program interventions that effectively contribute to the eradication of GBV in the South African community.

Intimate partner violence

Intimate partner violence is a prevalent feature of intimate relationships and is a widely acknowledged norm (Jewkes et al, 2002; Wood & Jewkes, 1998). Forms of violence identified through previous research included 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). In the different studies, the extent of the problem has been variable and is 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 one of the highest levels of physical intimate partner violence. Over 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 the relationship (Gupta et al., 2008). Other studies based on male samples found that one in four men had been violent towards their 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.

The Medical Research Council's Three Provinces Study showed gaps in the proportion of women reporting rape and women reporting rape to the police stations around the country (Jewkes et al., 1999). This found a rate of being "physically forced" into sex as 1 300 per 100 000 women aged 18-49 years (Jewkes et al., 2001). In the same year the rate of rape reported to the police was 210 per 100 000 women of all ages (SAPS, 1999). These rates show that at most 1 in 9 cases are reported to the police.

Femicide



South Africa has a rate of intimate femicide-suicide, (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[7]. The 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 mortuary files, autopsy reports and police interviews. Among 1 349 perpetrators of intimate femicide, 19% committed suicide within a week of the murder. The homicide rate of women was six times the global average, and intimate partners killed half of all women. Suicide after intimate femicide was more likely if the perpetrator was from a white rather than an African racial background. The study showed that 92 of the deaths of legal gun-owning perpetrators and their victims might have been averted if this group of perpetrators did not own a legal gun. This highlights the public health impact of legal gun ownership in cases of intimate femicide-suicide.

Gender-based violence and the Victims' Charter

The Commission for Gender Equality (CGE) implemented a study to assess whether police stations and courts possessed the necessary capacity to ensure victims of GBV are able to realise the rights enshrined in the Charter. The study focused on a number of police stations and courts in all nine provinces, with a sample of provincial NPA, Dept of Justice and Constitutional Development and Thuthuzela Care Centre employees. Implementation of the Victims' Charter was characterised by the following difficulties:

- lack of uniformity and knowledge about the Charter;
- staff challenges, shortage of magistrates and delays in processing court order forms;
- inadequate and inappropriate responses from police;
- disparities in statistics regarding cases opened and successful convictions and sentencing;
- inadequate vehicles to transport victims to places of safety and lack of special rooms at SAPS stations for receipt of domestic violence complaints;
- lack of anti-rape strategy in most police stations;
- inadequate capturing of GBV data and statistics at police stations such as the nature of assault, and profile of victims and perpetrators of GBV.

The study established that there is a need for increased knowledge and skills on handling GBV among police officials, including training on the identification and handling of GBV related cases. There is also need for increased access to professional services provided by social workers, psychologists and related disciplines in police stations and courts, and to supporting resources. The study also recommended an improvement in data collection, particularly gender-disaggregated data. This calls for improved systems and capacity in defining, collating, compiling and retrieving statistical data on GBV and related cases. There is also need for improved co-operation among Victims' Charter partners to enable better access to sites and information.

Previous research in Western Cape

A number of studies have been carried out on GBV in Western Cape:

Prevention in Action (PIA): Lessons Learned and a model for social mobilisation to address VAW in South Africa

Project Concern International (PCI), in partnership with the Western Cape Network on Violence Against Women (WCNOVAW) and the KwaZulu-Natal Network on Violence Against Women, implemented a Prevention in Action (PIA) programme in South Africa. The PIA programme was implemented in the Khayelitsha sub-district in the Western Cape (WC) and the

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

eThekwini District in KwaZulu-Natal (KZN), and its objective was to reduce the prevalence of physical and sexual violence against women who were most vulnerable to HIV infection in these provinces.

In 2009, a baseline study was undertaken, and findings showed that respondents knew that VAW was wrong. A final study was conducted at the end of the four-year PIA programme to understand how it had fostered deeper understanding in the strategies to prevent VAW.

An analysis of 2429 action narratives documented by the programme over an 18-month period informed understanding of the transition from inaction to action in engaging with VAW. A fair proportion of violence that was addressed was severe and led to police involvement or other legal processes being followed. According to the narratives almost half (48%) of the cases were resolved with a quarter (24%) reporting a legal outcome such as arrest, an interdict or a protection order. One in seven (14%) included resolution through counselling, and 6% involved improving community safety.

Surveys conducted in Khayelitsha and Wentworth at the end of the programme period provided insight into community perspectives. Around a third of the participants professed that VAW had decreased over the past year as a result of the PIA programme, while another third actually believed that VAW had increased. Overall the programme proved to be effective in addressing and preventing VAW in communities and as such is recommended to be replicated in other settings.

Source: KZN GBV Baseline Study 2013

Social constructions of gender roles, gender-based violence and HIV/AIDS in two communities of the Western Cape, South Africa (Strebel et al., 2006)

Strebel and colleagues undertook a qualitative study investigating how women and men in two black communities in the Western Cape constructed their gender identities and roles, how they understood gender-based violence, and what they believed about the links between gender relations and HIV risk. The methodology included conducting 16 key informant interviews with members of relevant stakeholder organisations and eight focus group discussions with community members in single-sex groups. Key findings included the perception that although traditional gender roles were still very much in evidence, shifts in power between men and women were occurring. Also, communities regarded gender-based violence as a major problem, fuelled by unemployment, poverty and alcohol abuse. HIV/AIDS was regarded as particular problem in African communities, with strong themes of stigma, discrimination, and especially "othering". Developing effective HIV/AIDS interventions in these communities will require tackling the overlapping as well as divergent constructions of gender, gender violence and HIV that emerged in the study.

GBV against women with psychosocial and intellectual disabilities in South Africa: promoting access to justice

The Centre for Disability Law and Policy, in partnership with the Cape Mental Health Society and the Gender, Health and Justice Research Unit initiated a research project in 2012 in the Western Cape, Gauteng, and KZN. The objectives of the research included:

- Gathering knowledge on the barriers that make the South African criminal justice system less accessible to women with disabilities experiencing gender-based violence, with specific reference to women with intellectual disabilities and with psychosocial disabilities;
- Gathering knowledge on examples of existing 'good practices' in addressing these barriers; Formulating recommendations to improve access to justice for disabled women experiencing gender-based violence in South Africa.

Researchers conducted approximately 57 interviews with representatives from organisations that provide services to women with disabilities as well as those that provide indirect services (such as organisations for women who have experienced gender-based violence, sometimes including women with disabilities). They also held focus group discussions with women with psychosocial disabilities to examine their perceptions of the barriers experienced when victims approach the police and courts.



Research Findings

Women with disabilities and particularly women with intellectual and psychosocial disabilities are often so far removed from the legal system (literally and figuratively) that access to justice is not seen as a priority. In all the provinces, including in the Western Cape, the number of cases presented to service-providing organisations (other than Cape Mental Health Society) was very low.

The research found significant differences between the three provinces in the way that service providers dealt with cases of GBV against women with intellectual and psychosocial disabilities. In the Western Cape, the Sexual Assault Victim Empowerment (SAVE) programme plays a crucial role in court preparation and assessments, and organi-sations in the GBV sector are aware of and exposed to disability issues. They also benefit from a strong and established referral network across GBV and disability service providers, and share expertise and information where it is relevant. In KZN, one organisation has a programme similar to SAVE, although it was found that some of the formalised features were absent.

However, in the rest of KZN and Gauteng the researchers were unable to identify dedicated programmes providing specialised services to adult women similar to those of the SAVE programme. Attempts were made in Gauteng to accommodate women with intellectual disabilities in services provided for children, but without dedicated fund-raising and attention to programme planning, these initiatives disintegrated, especially given that "children's services" are already inadequate.[8]

The Women's Health CoOp in the Western Cape

This was a randomised controlled trial sponsored by the National Institute on Drug Abuse (NIDA) and Research Triangle Institute (RTI) in collaboration with the Medical Research Council (MRC). The aim was to examine the effectiveness of a woman-focused intervention for high-risk behaviours in either a group or individual format and to examine the differences between black and coloured women across pre- and post-intervention measures of alcohol and illicit drug use and sex risk behaviours.

(2004-2006: Dr Wendee Wechsberg, principal investigator)

[8] Gender based violence against women with psychosocial and intellectual disabilities in South Africa: promoting access to justice.

Key findings

- Women significantly reduced their high levels of alcohol use and reduced dagga and crack cocaine use at 3-month and 6-month follow-ups;
- Women learned negotiation and condom-use skills and showed a significant increase at the 6-month follow-up in the percentage who were using condoms with their main partner at last sex act, and in the past 90 days, even under the influence of drugs;
- Women learned violence prevention strategies and showed a continued decrease at three and six month follow-ups in violence perpetrated by their main partners.

Why this research?

This study is imperative particularly in Western Cape since, to date, there is no documented study on the prevalence of GBV in a community with a representative sample of women and men across this province. So far studies that have been undertaken within this field include the Three Provinces Study conducted by the MRC in Mpumalanga, Eastern Cape and the (then named) Northern Province in 1998, and the three separate GBV Indicators studies undertaken by GL in partnership with the MRC in Gauteng, Limpopo and KZN.

The current study provides prevalence data on women in WCP and comparative data in the form of reports on perpetration of violence 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. Thus, the research provides important insights into the prevalence and perpetration of the different forms of violence in WCP at the time it was completed.

Conclusion

GBV remains rife in South Africa and continues to have negative consequences on the health and social well-being of women and their families, as well as on the economy of the country (Suffla, 2004). Studies throughout the country show shocking statistics on the magnitude of GBV. Thus, this study provides important data on the magnitude of violence especially against women in Western Cape. This information is crucial, as it will be used for policy implementation. The baseline indicators will also help in the monitoring and evaluation activities of the province as the country aims to halve GBV by 2015.

CHAPTER 2
METHODOLOGY



Entrepreneurship Training, George Municipality, Workshop Participants' Group Discussion Western Cape, South Africa 2013. *Photo: Ntombentsha Mbadlanyana*

Key facts

- The Western Cape GBV Indicators study measured GBV experience and perpetration, gender attitudes, selected health-related behaviour and exposure to prevention campaigns among women and men.
- The study used a mixed method approach that combines both qualitative and quantitative methodologies.
- A cross-sectional household survey measured GBV prevalence, HIV risk behaviour, pregnancy history, mental health, help-seeking behaviour after experiences of GBV, gender attitudes and exposure to campaigns.
- Researchers analysed administrative data from the police, shelters, health services and social services to substantiate survey data.
- The "I" Story methodology is a qualitative approach used to gather personal experiences of physical, sexual, emotional and economic violence.
- Researchers also employed administrative data to document the extent of GBV as recorded in the public sector service.



"I am Teneille. About a year and a half ago, I met a guy and thought he was the man of my dreams. We started dating and everything was OK in the first week. I knew he was on drugs but he said he would quit once we were together. Little did I know what I was getting myself into. It started with verbal abuse but that quickly evolved to emotional abuse as he started keeping me away from my friends and family. He started beating me and said he did it because he loves me and because my family doesn't care or love me. As the days went by the abuse just got worse.

He started using drugs every day and when he was high, he started arguments. This is the first abusive relationship I have been in and I have more than one scar to remind me of what I have experienced. About four months ago we found out that I was pregnant but the abuse never stopped. He promised me that one thing that would change him would be a child. Two weeks after we got the news of my pregnancy I started having severe pains in my stomach. I went to the hospital and they immediately put me on drip and said I had to go to Somerset Hospital for an operation because the baby was growing in my left tube. When he heard this he blamed me for losing the baby. Later he promised me that he was going to change his abusive behaviour. When I got home on the day I was discharged, he beat me up again. The stitches I had received nearly tore open.

As the abuse escalated, I became physically ill, throwing up, no appetite and just tired all the time. I kept on praying and then one day I received a call that I got a job and I thought, 'This is it.' I thought that was my chance to finally get away from him. He allowed me to go and work because he needed the money for his drug habit. When I finished work one day I asked the taxi driver to drop me off at my church because I knew I could get help there. At the church they called a shelter that could assist me. That's how I ended up in the Saartjie Baartman Centre, where I am getting counselling and support. I will be appearing in court soon because I'm also proceeding with a protection order against him. When I face him this time I will not fear him, I have gained strength after what he has done to me."

This story summarises the essence of this whole report. It highlights the different forms violence that occur within intimate relationships. It also touches on the various negative effects of violence as well as support structures that can assist survivors of violence. After Teneille finally decided she had enough of the abuse, she got assistance from the Saartjie Baartman Centre.

This chapter outlines the project aim, key research questions, and methods employed in this study to measure the different forms of GBV, including rape. The five tools provide several different prisms from which to view GBV. 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 VAW 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."[9] The declaration 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;

[9] 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

- Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;
- Physical, sexual and psychological violence perpetrated or condoned by the state, wherever it occurs.[10]

For the purposes of this study, GBV includes:
- 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;
- Sexual harassment.

Project aim

This study is inspired by the SADC Protocol on Gender and Development which sets the target of reducing current levels of GBV by 50% by the year 2015. It seeks to test the GBV indicators developed through expert consultation, and provide extensive data of GBV in the Western Cape province of South Africa. The Western Cape GBV Indicators study will contribute to the reduction of GBV by providing data to monitor and evaluate government and civil society's efforts to halve levels of GBV by 2015. The findings will be useful for a comprehensive assessment of the extent, effects and the response to GBV as provided by the National Action Plan to End Violence Against Women and Children.

The study's main objective is to pilot the methodology and measures of GBV experience and perpetration, gender attitudes, selected health-related behaviour and exposure to prevention campaigns among women and men in Western Cape. Specifically, the project aims to:

- Quantify the prevalence of GBV in its different forms and determine the extent of underreporting; 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 related services;
- Assess the way GBV is covered by the media, how it is perceived by audiences and the extent to which the media plays a role in helping to end (or perpetuate) GBV;
- 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 respondents to the prevalence study;
- Provide pointers for government and civil society in the Western Cape 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 the Western Cape?
- What is the physical, social, and economic impact of GBV on society?
- What is the response of public services to GBV in the Western Cape?
- What is the level of political commitment to address GBV shown by the national government?
- To what extent is the media helping to end or to perpetuate GBV in the Western Cape?
- What is the impact of prevention interventions and mainstream media on GBV in the Western Cape?

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 the Western Cape.

[10] Ibid.

The project components are:

- Prevalence and attitudes household survey;
- Analysis of administrative data gathered from the criminal justice system (police, courts), health services, and government-run shelters;
- Qualitative research and collection of first hand accounts of women's experiences of, and men's perpetration of, GBV;
- Media monitoring;
- Political content and discourse analysis.

Prevalence and Attitudes Household survey

Researchers used the prevalence and attitudes survey to investigate the extent and individual effects of GBV, 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.

Description of the questionnaire

Researchers compiled 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, GBV risk behaviour, fathering, and exposure to prevention campaigns.

The questionnaire responses provide the following information:

- 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 in 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;
- An exploration of economic abuse and its relationship to GBV.

Sampling

The sampling method is a two-stage proportionate stratified design. First, researchers drew a random sample of the primary sampling units (PSUs). PSUs were the main areas in which to locate the households for men and women. Researchers took the following steps to obtain a representative target sample of 1 500 household members:

- Obtained the most current list of wards from the local municipalities (LMs) and compiled these into a dataset;
- Randomly selected 75 wards in the province with due consideration of population groups;
- Obtained maps of each selected ward through the LMs or Google Earth;

- Divided wards into four enumeration areas (EAs), depending on the population of each ward (but four for an average ward of 10 000 people - this information is included on the sample);
- Randomly selected one EA from every ward (approximately 400 households per EA);
- Allocated every second or even-numbered EA for female participants; allocated every first or odd-numbered EA for male participants only;
- Used maps to enumerate the EAs and if these were not available, researchers physically walked the EA and counted the number of households. Then, with field managers/supervisors they calculated an interval to ensure random and stratified sampling to yield 20 interviews in each EA;
- Supervisors selected a random starting point such as a school, park, cemetery or hospital and marked this on the map;
- With no allowance for substitution, interviewers endeavoured to complete 20 interviews in each EA.

Inclusion criteria

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 had to be sleeping in the selected household for at least four nights a week to be considered part of it.



Field managers for the Prevalence and Attitudes Household survey informed local police about their activities to ensure cooperation. *Photo by Trevor Davies*

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 selection;
- 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;
- 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, e.g. 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 and Umhlaba Development Services held a training session in June 2011. 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 assistant (PDA) equipment and related activities, adherence to methodology, and communication of the deployment schedule. The training sessions included the following:

- Presentations 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 fieldwork implementation planning (including setting up accountability structures);
- Methodology and sampling (and adherence to this);
- 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 identification numbers. The study thus cannot link individuals to their questionnaires.

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

Data collection

The research team conducted 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 14 July to 6 September 2011. From each household, the researchers recruited only one randomly-selected eligible person (over the age of 18 years, male or female depending on the EA allocation). 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 the safety of respondents, researchers did not interview men and women from the same household or EA.

Researchers administered the questionnaires using PDAs. The participants chose their language of preference and the interviewer read each question and associated answer choices as presented on the PDA screen. 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 PSUs 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). They used Pearson's chi-squared test, to test associations between categorical variables.

To meet our 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. Therefore no causal inferences can be made from the results.

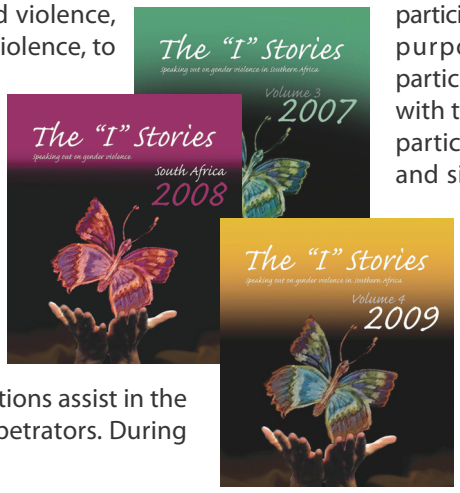
Ethics Considerations

GL received approval to conduct this study as an extension to the Gauteng Study from the Medical Research Council Ethics Review Committee in July 2010.

Interviewers invited all participants to participate voluntarily and told them that non-participation would not affect them in any way. They informed respondents that they could skip any question they chose and could withdraw from the interview completely at any time. Respondents received an information sheet about the study, which interviewers read to them when necessary. Once interviewers had fully informed respondents about the study, they asked them to sign consent for the interview. To ensure anonymity researchers identified all questionnaires with non-consecutive study identity numbers. As a result, the study has no ability to link identified individuals to their questionnaires.

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 worked with women who had experienced violence, and men who used to perpetrate violence, to write their stories. These personal accounts were published 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 are aware of 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:

- Are women able to identify the various forms of abuse (physical, sexual, psychological or economic)?;
- How many women interviewed are experiencing the various forms of abuse?;
- What are the causes of violence against women?;
- What are the effects of violence against women (physical, psychological, economic or social)?;
- How does abuse impact on ability of women to leave abusive relationships?;
- What support has been available for women experiencing abuse?

Process

In the Western Cape project, the Saartjie Baartman Centre provided the 18 women survivors who participated in the "I" Stories workshops. The organisation co-facilitated the workshops together with GL staff. Facilitators showed participants copies of other "I" Stories published by GL. The main purpose was to build rapport and make participants feel comfortable by explaining to them exactly what their stories will be used for, and how to use a pseudonym if they felt uncomfortable using their real names.

The facilitators made it clear to survivors that they did not have to do anything and that their participation was voluntary and for research purposes. Facilitators helped those participants who understood little English, with the translation of consent forms. The participants completed the consent form and signed it. Participants also specified where and how they wanted their story used and whether their photographs could be used. Participants also voluntarily gave consent to be interviewed in future. A few of the survivors were illiterate and GL staff assisted them in writing down their stories.

Ethical Considerations

The facilitators:

- Informed participants how GL would use and distribute their stories;
- 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;
- 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, the SAPS, Department of Justice and Constitutional Development, and Department of Social Development.

The main purpose of collecting and analysing administrative data was 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 GBV, more especially of intimate partner violence, mainly due to the high levels of under-reporting.

In the words of 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.*"[11]

However, 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 areas in need of improvement.[12]

Description of data

Data requested from the respective institutions included:

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

In this report, the administrative data was analysed in conjunction with the results of the household survey. This helps provide some indication of current levels of underreporting of GBV as well as of the adequacy of public services responses and their compliance with legislation and policies.

Public pronouncements analysis

Public pronouncements by political leaders form an essential part of social behaviour as they dominate the way people interact with peers and superiors in accordance to what is expected of them, what they think is possible and who they are.[13] Public pronouncements and discourse also contribute to the "creation and/or transformation of the society and culture" through re-articulating three domains of social life: a) representations of the world; b) the social relations between people; and c) the individual and social identities of people.[14] In this vein, the messages passed on by politicians in their speeches have an impact on the way their constituencies access knowledge, shape their opinions on GBV and act thereon. Political discourses are useful as a strategic public awareness and accountability tool for civil society. In terms of the overall Indicators project, analysing the speeches and pronouncements of key political figures assisted in framing and triangulating the findings of other study components.

[11] Walby, S, op cit.
[12] Ibid.
[13] Rudling, A, (2009), La Señora Presidenta. Feminist policy-making by female Latin-American presidents? Quoting Fairclough, Norman (1995). Critical Discourse Analysis. A Critical Study of Language, New York: Longman Publishing Inc., available at: http://hh.diva-portal.org/smash/record.jsf?pid=diva2:239541
[14] Op. Cit quoting Romero, Juan Eduardo (2005). "Usos e interpretaciones de la historia de Venezuela en el pensamiento de Hugo Chávez" in Revista Venezolana de Economia y Ciencias Sociales, Volume 11, Number 2, available at: http://hh.diva-portal.org/smash/record.jsf?pid=diva2:239541

Aim

The analysis of available speeches, statements and pronouncements is aimed at establishing the prevalence, consistency and commitment to addressing GBV by key senior political figures. More specifically, the aim was to assess the level of conceptual clarity on the structural causes of the problem, how holistic the alternatives offered to the survivors are, and the level of commitment to addressing the issue within the framework of state accountability.

Sources of data

To measure the prevailing GBV discourses articulated by political leaders, researchers collected and analysed the content of speeches made by key government functionaries. Researchers undertook desktop research to find speeches online. This included visiting the Government Communication and Information System (GCIS) and all official departmental websites displaying published speeches.

Media monitoring

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

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 GBV 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 GBV coverage break down with regard to these genres?;
- Where do the stories come from (international, regional, national, provincial, and local)?;
- How does GBV coverage break down with regard to origin of stories?;
- On average, how many sources per story are there on GBV stories?;
- 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.

Quantitative research

The quantitative monitoring consisted of capturing data on the media's coverage of gender, GBV, and HIV and AIDS using a coding instrument. Researchers captured data 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:

- Filling in standard forms each day 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 that the monitors encountered;
- Entering of data into a database;
- Quality control by GL;
- Delivery of the database by email to GL for synthesis into one central database that made this regional overview report possible, as well as country comparisons with regional averages;
- Data analysis and generation of graphs.

Qualitative research

After the quantitative monitoring, monitors selected articles for further analysis. The qualitative analysis enhanced and strengthened the quantitative findings. These case studies highlighted best practices in the coverage of gender, HIV and AIDS, and GBV as well as areas that needed to be improved. The case studies served 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 and perspectives in the story?;
- What are the missing stories?.

Triangulation

Table 2.1: 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 2.1 shows how these tools interrelate and how the research uses them to triangulate findings throughout the research to answer key questions relating to extent, effect, response, support, and prevention. The flagship tool was the prevalence and attitudes study, justified on the basis that statistics obtained from administrative data do not cover many forms of gender violence, and even those that are covered are underreported. However, the "I" Stories, or lived experiences, gave a human face to all aspects of the research. The administrative data, and media monitoring provided key insights in relevant areas. Triangulation helped verify and strengthen the findings and provided key insights for policy making and action planning.

CHAPTER 3
EXTENT OF GBV

Key facts

Lifetime prevalence

- Thirty-nine percent of women interviewed experienced GBV at least once in their lifetime, and 39% of men interviewed perpetrated GBV at least once in their lifetime.
- IPV is the most common form of GBV experienced by women followed by abuse in pregnancy, attempted rape, non-partner rape and sexual harassment.



Take Back the Night Mosselbay Summit Study Visit, Western Cape, South Africa. *Photo: Ntombi Mbadlanyana*

- Forty-four percent of ever partnered women experienced, while 37% of ever partnered men reported, perpe-tration of some form of IPV in their lifetime.
- Emotional IPV is the most commonly experienced and perpetrated form of IPV in lifetime experiences. Forty percent of ever partnered women experienced, while 30% of ever partnered men perpetrated, emotional IPV in their lifetime.
- Twenty-five percent of ever partnered women experienced, while 20% of ever partnered men perpetrated, physical IPV in their lifetime.
- Thirteen percent of ever partnered women experienced, while 9% of ever partnered men perpetrated, economic IPV in their lifetime.
- Thirteen percent of ever partnered women experienced, while 5% of ever partnered men perpetrated, sexual IPV in their lifetime.
- Thirteen percent of women experienced abuse during pregnancy.
- Seven percent of women were raped by non-partners in their lifetime whereas 15% of men reported raping a non-partner in their lifetime.
- There was under-reporting of IPV and rape to the police and medical providers by women in lifetime experiences.

Prevalence rate 12 months prior to the study

- More than a tenth (12%) of women experienced, and men perpetrated, some form of IPV in the 12 months prior to the survey.
- Emotional IPV was the most commonly experienced and perpetrated form of IPV 12 months prior the survey.
- Equal proportions (9%) of ever partnered women experienced and men perpetrated emotional IPV in the 12 months before the survey.
- One percent of women were raped by non-partners in their lifetime while 2% of men admitted perpetration.
- There was under-reporting of experiences of IPV and rape to police and medical providers by women in the 12 months prior to the study.



"I, Candice, grew up poor and didn't have much as a child. My parents divorced for the second time when my father started taking drugs. My mother got involved with a man who sexually molested me. When I was four years old, she got involved with another man. I remember my mother fighting with a woman in my presence. I later found out that the man my mother was dating was married. I was heartbroken.

I became friends with a girl who stayed in a block of flats away from where I stayed. She invited me to her birthday party. I met her father and his presence instilled a sense of fear in me. When it was bed time I asked if I could sleep over and they agreed. That was the first time that my friend's father hit me with a belt. He said my mother had given him permission for him to beat me but I later found out she never knew about the incident.

My mother married him two weeks later and on their wedding night I witnessed her being beaten for the first time. I saw him rape her numerous times. He also put her face under the shower and dragged her through rose bushes. I also remember a time she came running to my room covered in blood so that she could hide and protect herself. My mother got involved in criminal activities to provide for her husband and she often neglected me. Sometimes, my stepfather would come home drunk and beat me. He would pull down my panty and beat me on my back until I blacked out. Then he would tell me to cool off in the swimming pool and said that if I told my mother he would kill her. I was so scared of this man and resorted to hiding myself in the top of my cupboard when I returned from school.

The first time anyone found out I was being abused was when I was in the change room at school. My teacher saw the bruises and asked me what happened. I was afraid to tell her but eventually did after she promised me that everything would be okay. The school contacted my mother and that evening she confronted him about it, and he physically abused us and I suffered a cracked rib and cheekbone. When I was 10 years old he was caught in the bath with me but nobody did anything about it.

At the age of 13 I met and got involved with a 24-year-old man for three years and during that time he exposed me to pornography and other very uncomfortable things. I was raped by three men and three weeks later I was beaten by my stepfather. I was taken out of school in Grade 8 by a psychologist who thought I was too stressed at home and at school.

By the time I was 16, I was already taking drugs every day until I was 18. I also found out that my stepfather had been putting dope (heroin) in our food daily since I was seven years old. I met my eldest son's father at the age of 17 and he was a charmer. He also used drugs. After four months of dating, he demanded sex from me.

He insulted the way I looked and said things like 'look how nice other girls dress, they have straight blonde hair and yours is curly'. He cheated on me on numerous occasions though he accused me of infidelity. The constant beatings resulted in a miscarriage. When I fell pregnant again, he wanted me to have an abortion and spiked my drink with drugs. I got sick and a doctor had to make a house call. One day, he punched my three-month-old son in the stomach and that's when I decided to leave him.

My husband never helped me with the house chores or the children. He beat me when I was pregnant. He punched me countless times, kicked me in the back and hit my head against the ground. I laid charges against him but dropped them because he promised to change but three weeks later, it was the same again. He lost us our last home and that's how I ended up in a shelter, and because I had no job."

This story shows that females of all ages can be victims of violence. From a very tender age, Candice was sexually molested. She also saw her mother suffering domestic abuse. Later in life, she also experienced abuse at the hands of her intimate partner. This shows the cyclical nature of GBV: from infancy to old age, the life of an average woman is characterised by abuse. This chapter outlines the extent of the different forms of abuse in the Western Cape Province.

According to the UN Declaration on the Elimination of Violence against Women, GBV against women includes violence perpetrated by the state, by intimate partners and by non-partners. GBV includes physical, sexual and emotional violence in family including battering, dowry-related violence and marital rape. GBV also extends to non-spousal violence and violence related to exploitation and physical, sexual and psychological violence occurring within the general community. This includes rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere (Amnesty International Report, 1995: 8). The forms of GBV measured in this study are intimate partner violence (IPV), sexual harassment and rape. This chapter presents the rates of different forms of GBV experienced by women and perpetrated by men in their lifetime and in the 12 months before the survey.

Sample description

The survey consisted of 750 women and 742 men from different demographic and socio-economic backgrounds from across the province. Researchers collected background information about the participants.

Table 3.1: Demographic, socio-economic and relationship characteristics of participants

	Women		Men	
	%	N	%	N
Age group				
18-29	31.6	237	56.0	415
30-44	46.7	350	25.9	192
45+	21.7	163	18.1	134
Total	100	750	100	741
Level of education				
High school incomplete and lower	43.3	325	41.2	306
High school complete	56.7	425	58.8	436
Total	100	750	100	742
Race				
Black African	29.2	219	23.5	174
Coloured	49.7	373	48.6	360
Indian	0.8	6	1.2	9
White	18.4	138	26.2	194
Other	1.9	14	0.5	4
Total	100	750	100	741
Have you worked to earn money in the last 12 months				
No	54.1	406	43.2	319
Yes	45.9	344	56.8	420
Total	100	750	100	739
How much did you earn before tax and including benefits				
R 1-500	3.4	11	3.5	14
R 501-1 000	11.3	37	6.0	24
R 1 001-2 000	26.1	86	15.8	63
R 2 001-3 000	31.0	102	40.5	161
R 2 001-5 000	16.1	53	17.4	69
R 5 001-10 000	10.3	34	12.3	49

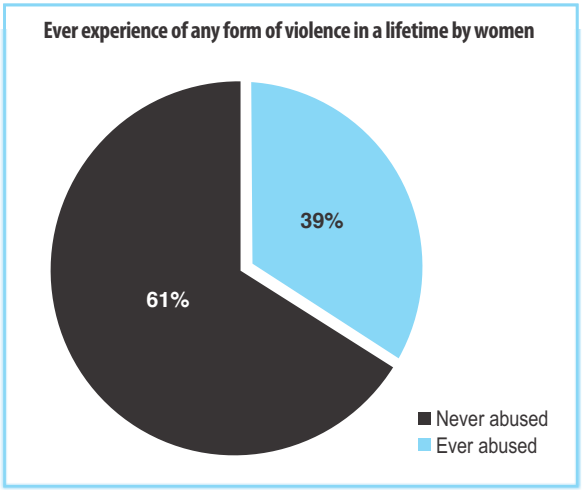
	Women		Men	
	%	N	%	N
R 10 000-20 000	1.8	6	4.5	18
Total	100	329	100	398
Ever in an intimate relationship				
No	8.5	64	9.1	68
Yes	91.5	686	90.9	675
Total	100	750	100	743
Ever had sex				
No	11.0	82	11.4	83
Yes	89.0	661	88.6	647
Total	100	743	100	730

Table 3.1 shows that the majority of the sample population was older than 30. Forty-seven percent of women and 26% of men were within the ages of 30-44 years. Twenty-two percent of women and 18% of men were 45 years and older. More than half of the women and men had completed high school or higher formal education. The sample was also predominantly coloured people with 50% of the women and 49% of the men being of the coloured race. Female and male black Africans were 29% and 24% of the population respectively. The majority of the women and men were sexually active and had had an intimate relationship.

GBV in a lifetime

GBV is a complex issue and there is a gap in literature backed by empirical evidence on the extent of violence against women (Tjaden, 2000). The current study examined the extent and nature of GBV in the Western Cape Province. It measured both the lifetime prevalence of GBV and prevalence in the 12 months prior to the survey. Researchers ascertained lifetime prevalence when a respondent admitted to ever experiencing or perpetrating any one of the acts of GBV.

Figure 3.1: Any experience of GBV by women or perpetration of GBV by men



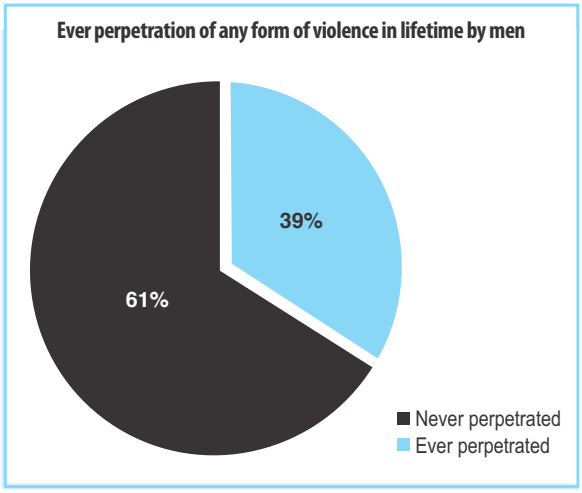


Figure 3.1 shows that 39% of women participating in the study had experienced some form of violence in their lifetime while an equal proportion of men (39%) admitted to perpetrating violence against a woman. This measure of GBV included all forms of violence occurring within intimate partner relationships and non-partners. This finding is a telling sign of the high levels of lifetime experience of GBV among women in the province. Social institutions that legitimise and ignore VAW promote the high prevalence of VAW. Compared to the other provinces where the study has been undertaken, Western Cape records the third highest experience prevalence rate after Limpopo at 77% and Gauteng 51%. KZN recorded the lowest at 37%.

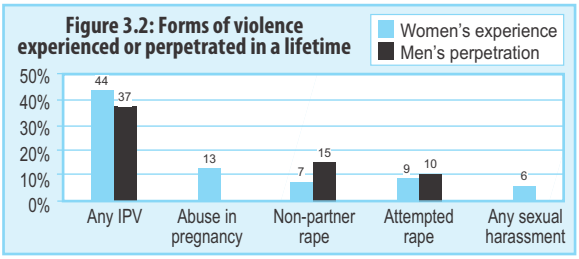


Figure 3.2 shows that the predominant form of violence experienced by women and perpetrated by men is intimate partner violence (IPV). Forty-four percent of women experienced, while 37% of men perpetrated, IPV. The domestic sphere places women at greater risk of gender violence because society has given men greater control and power in sexual relationship (Strebel, 2006).

More than a tenth (13%) of women experienced various forms of violence during pregnancy in their lifetime. Women were also vulnerable to violence from non-partners. Seven percent of women experienced, and 15% of men perpetrated, non-partner rape. Nearly a tenth (9%) of women experienced attempted rape in their lifetime and 6% experienced sexual harassment.

Intimate partner violence

Intimate partner violence (IPV) encompasses any physical, emotional, economic or sexual violence occurring between partners in an intimate relationship. The intimate relationship is not restricted to married couples but extends to unmarried couples such as girlfriend and boyfriend. This type of violence is often considered normal when it should be considered a criminal act (Bott, 2005). Bonds formed in intimate relationships, and economic and emotional dependency make women hesitant to report acts of violence against them (Bott, 2005). Forty-four percent of the women surveyed had experienced, while 37% of the men had perpetrated, some form of IPV in their lifetime.

Physical violence is the intentional use of physical force, potentially 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, use of restraints or one's body, size, or strength against another person.

Sexual violence includes abusive sexual contact as well as 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. It is also the 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 because of, for example, illness, disability, the influence of alcohol or other drugs, intimidation or pressure.

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.[15]

[15] Saltzman et al 2002.

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

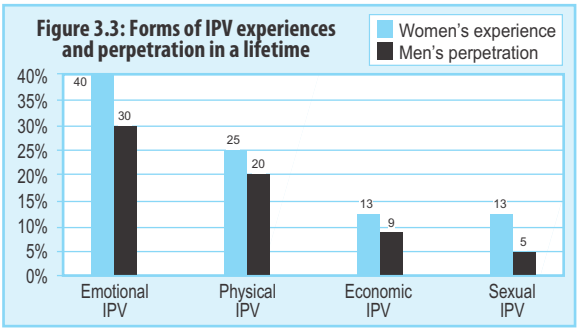


Figure 3.3 shows that emotional violence was the most experienced and perpetrated form of IPV with sexual violence being the least. Four out of ten (40%) of the ever partnered women experienced, while three out of ten (30%) of ever partnered men admitted perpetration of, emotional violence. This tallies with the trend observed in the other provinces. A quarter of women experienced, and 20% of men perpetrated, physical IPV. Thirteen percent of women suffered both economic and sexual abuse. The Western Cape is the only province where higher proportions of women compared to men reported all forms of IPV. This shows that women were more forthcoming in admitting experience of the various forms of IPV than men were in admitting perpetration. This might imply that women felt empowered to speak out about the violence that they suffered in their domestic lives.

Megan recounts the emotional abuse she suffered: *"I would come back home to find prostitutes sleeping there. I had no say and if I confronted him about it he would call me names and make me be the one in the wrong. If I told him they must leave, he would tell me that I should leave instead."*

Emotional IPV

Researchers assessed emotional abuse with six questions that asked about experience or perpetration of a series of different acts that were controlling, frightening, intimidating or undermined women's self-esteem. The survey asked women participants if a current or previous 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. Researchers asked men if they had done any of these things to a current or previous female partner.

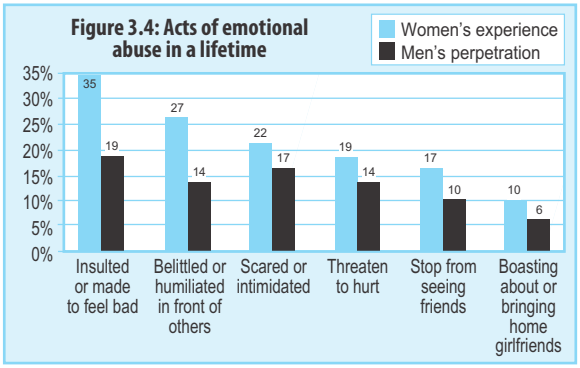


Figure 3.4 shows that the most commonly experienced act of emotional violence was being insulted or made to feel bad. Thirty-five percent of the women were insulted or made to feel bad by their partner while nearly a fifth (19%) of men admitted to perpetrating this form of abuse. Twenty-seven percent of women were humiliated in front of others, 22% intimidated, 19% stopped from seeing friends, and a tenth said their partners boasted about or brought girlfriends home. Physical abuse may accompany emotional abuse although some women have said that emotional abuse and degradation is more difficult to endure than the physical abuse (Heise et al, 2002).

Acts of emotional abuse from 'I' Stories

Emotional abuse was also the most prevalent form of IPV among the 18 women who gave personal accounts of their experiences. More than half of the women (10) experienced emotional violence, half of these reported that they were insulted and called names by their partners. The accounts show that emotional abuse such as name calling is used by perpetrators to instil a sense of powerlessness and low social position in the women. Four women who experienced emotional violence reported that their partners had cheated on them or accused them of cheating. Some men questioned paternity of their children, insinuating that their partners had cheated. Two women reported that their partners prohibited them from visiting friends or relatives.

Physical IPV

Researchers in this study ascertained experience of physical IPV by asking five questions about whether women had been slapped, had something thrown at them, been pushed 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.

Physical IPV was the second most common form of IPV with a quarter of the women experiencing, and one in five of the men perpetrating, that type of IPV.

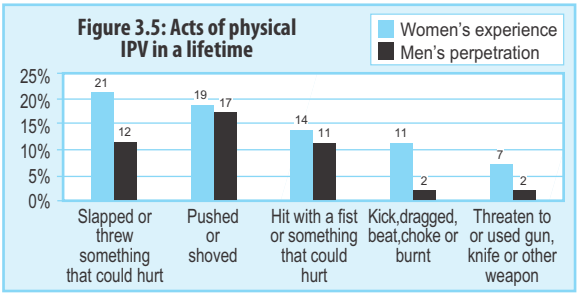


Figure 3.5 shows the most common act of physical IPV reported by the women was slapping or having something that could hurt, thrown at them (21%). Nearly a fifth (19%) of the women were pushed or shoved, 14% hit with a fist or dangerous object, 11% kicked, dragged, beaten, choked or burnt and 7% were threatened with a weapon. A lower proportion of men reported perpetration of these various acts of physical IPV.

"One night he became so aggressive that he punched me in the mouth and I started bleeding. I screamed loudly but no one bothered to check on me. The next morning, he stabbed me with a scissors in my left leg and I decided to leave... after two weeks I went back to him."
By Ayesha

Acts of physical abuse from "I" Stories

The "I" Story accounts indicated that eight out of 18 women experienced physical abuse. Acts of physical abuse included being beaten, smacked, pushed, punched, thrown on the ground, hit with a weapon, and receiving threats of deaths. Women are vulnerable to physical abuse due to unequal power to make household and sexual reproductive health decisions. In a society that does not punish male perpetrators, women are vulnerable to repeated abuse. Women who stay in the abusive relationship believing that the partner will change, or because they were advised to stick it out or were economically and emotionally dependent on the partner, suffer recurring physical abuse accompanied by sexual and economic abuse. Additionally, alcohol and substance abuse triggered and worsened violence in survivors' homes. Women are at greater risk of experiencing physical violence from a partner than from other people (Garcia-Moreno, 2005).

Table 3.2: Frequency of physical IPV

Frequency	Women's experience %	Men's perpetration %
Never	75.5	79.7
Once	12.9	11.7
More than once	11.7	8.6

Table 3.2 shows that more than three quarters of both the women and men never experienced or perpetrated physical violence. More than a tenth (12%) of

women suffered, while 9% of men perpetrated, physical IPV more than once in their lifetime. There was little difference between the proportion of women suffering physical IPV once in their lifetime and suffering it more than once. This suggests that women who experience physical violence once are at greater risk of repeat victimisation.

The findings show that family members and institutions such as the justice system offering support to survivors of violence should strengthen their response approaches. The justice system should be quick to offer appropriate help to the survivors as well as extend punitive measures to offenders to prevent repeat victimisation.

Economic IPV

Economic or financial abuse takes many forms, including:

- Controlling the finances; withholding money or credit cards;
- Giving the 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;
- Sabotaging a partner's job by making them miss work.[16]

This study looked at the following 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. Economic IPV was the third most prevalent form of IPV experienced by women (13%) and perpetrated by men (9%).

"I refused to give him money and one of his friends laughed at him and he asked them to leave. He grabbed me by my hair and sexually assaulted me to punish me and show who the man of the house was." Romalla

[16] http://www.4woman.gov/violence/types/emotional-cfm

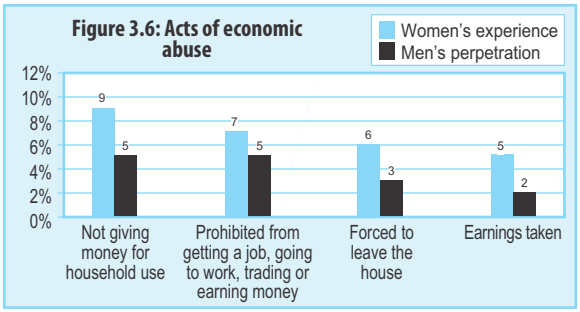


Figure 3.6 shows the most common act of economic abuse was being refused money for household use. Nearly a tenth (9%) of women were refused money for household use, and 5% of the men admitted to this. Seven percent of women were prohibited from going to work, 6% were forcefully evicted from the house and 5% had their earnings taken. Five percent of the men prevented their partners from going to work. Economic abuse of women in intimate relationships rests on unequal power distribution in terms of household and financial decision making. Women who are economically dependent on their husbands are less likely to report any violence against them (Bott, 2005).

Acts of economic abuse from "I" Stories

Seven of the 18 women experienced economic violence. Common acts of economic violence included deprivation of money or basic amenities and partners demanding money from them. Drug and alcohol abuse was implicated as a trigger and driver of economic violence. This indicates that there is a need to continue empowering women economically. However, it is very important to change the attitude of men about the use of violence in intimate violence first. Women in KZN experienced similar forms of economic violence. However, in KZN alcohol or drug abuse was not as much of a trigger as was the culture. The patriarchal culture with some of its repressive practices was the dominant driver of GBV in KZN.

Sexual IPV

Sexual violence[17] includes:

- 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.

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.

The survey assessed sexual IPV experienced by women with three questions inquiring if their current or previous husband or boyfriend had ever physically forced them to have sex when they did not want to. Questions also asked whether respondents had had sex with a partner because they were afraid of what he might do and whether they had been forced to do something sexual that they found degrading or humiliating. Thirteen percent of the ever partnered women reported experience of sexual IPV in lifetime. A lower proportion of the men (5%) reported perpetration of sexual IPV.

Table 3.3: Frequency of sexual IPV

Frequency	Women's experience %	Men's perpetration %
Never	87.2	95.0
Once	3.8	4.0
More than once	9.0	0.9

Table 3.3 shows that four percent of the women suffered sexual abuse by an intimate partner once in their lifetime. Nearly a tenth (9%) of the women were raped more than once in their lifetime. This is twice the proportion of women raped once, and may suggest that there is a pattern of repeat sexual victimisation among women. Only 1% of the men admitted to perpetrating sexual abuse more than once.

Acts of sexual abuse in "I" Stories

Sexual abuse was one of the most prevalent forms of IPV in the "I" Stories accounts. Seven out of 18 women suffered sexual abuse. Sexual abuse acts comprised coercion into having sex, having to do uncomfortable sexual activities, molestation and exposure to pornography. Sexual violence has serious consequences on the sexual reproductive health of women. Women are at higher risk of infection with STIs including HIV/AIDS. Other documented effects of sexual violence include unintended pregnancy and mental ill-health.

Abuse in pregnancy

Intimate partner violence can be prompted or intensified by pregnancy. Abuse in pregnancy may be due to a longstanding abusive relationship that continues after a woman becomes pregnant. It may also commence because of reasons such as unintended pregnancy or suspicion of birth control sabotage. In this study, we explored the occurrence of intimate partner violent behaviour towards pregnant women. We asked women if they experienced acts of abuse during any of their pregnancies.



[17] Violence and associated terms by Basil and Saltzman (2002).

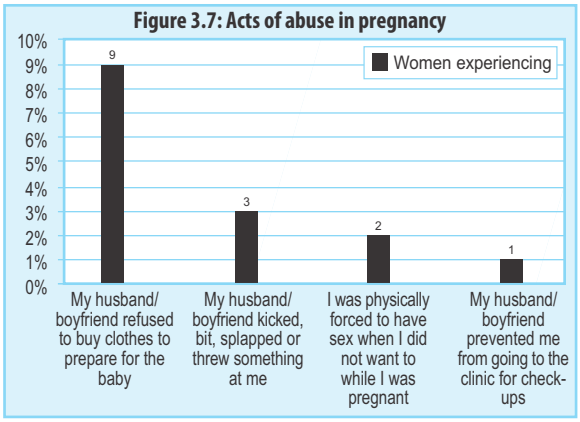


Figure 3.7 shows that some of the women experienced economic, physical, sexual and emotional abuse during their pregnancies. The most common act of abuse experienced was the partner refusing to buy clothes to prepare for the baby. Nearly a tenth (9%) of the women who were ever pregnant reported experiencing this. Three percent of the ever pregnant women suffered physical abuse while 2% were raped by their partners. One percent of ever pregnant women were prevented by partners from attending antenatal clinic during pregnancy. Seven women who were ever pregnant experienced abuse during at least one of the pregnancies. A study conducted in Germany that looked at stress caused by intimate partners, showed that high levels of stress during pregnancy can cause an unborn child to have lifelong mental scars.[18] Therefore, there is need to advocate for maternal stress and GBV screening in pregnant women in order to take to precautionary measures.

Non-partner rape

Studies show that South Africa has the highest rate of rape in the world (Jewkes et al, 2006). Some of the factors that trigger rape among men are an exaggerated sense of sexual entitlement and fulfilment of fantasies of power (Jewkes et al, 2006).

We assessed the rape of women by men who were not their intimate partner through three questions. The study asked women whether they had been forced or persuaded to have sex against their will by a man who was not a husband or boyfriend, or whether they had been forced to have sex with a man when too drunk or drugged to stop him. Lastly, we asked women whether they had been forced or persuaded to have sex with more than one man at the same time. The last question is an indicator of gang rape.



Take Back the Night Mosselbay Summit Study Visit, Western Cape, South Africa. *Photo: Ntombi Mbadlanyana*

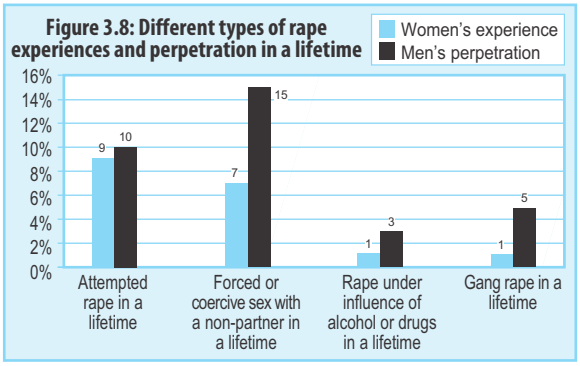


Figure 3.8 shows that attempted rape was the most common, and gang rape the least common, rape experienced by the women. Nine percent of the women suffered attempted rape while 10% of men

[18] http://www.dailymail.co.uk/health/article-2016452/Babies-born-stressed-mothers-struggle-emotional-scars-life.html

admitted attempting to rape a woman in their lifetime. Seven percent of women experienced, and 15% of men perpetrated, non-partner rape. One percent of women were raped under the influence of drugs or gang raped at least once in their lifetime. This calls for promoting positive attitudes of masculinity among men that should start among young boys.

Frequency of rape

The survey phrased the questions on rape such that the respondent provided information on the frequency of occurrence of incidents. Respondents could indicate whether they had been raped on one occasion or on two or more occasions.

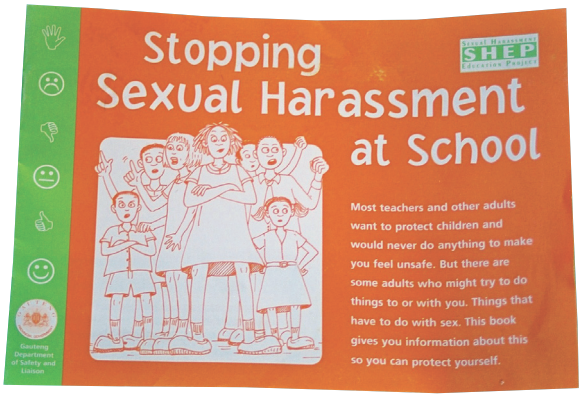
Table 3.4: Frequency of non-partner rape and attempted rape

Any non-partner in a lifetime	Women's experience %	Men's perpetration %
Never	93.3	85.0
Once	3.4	10.2
More than once	3.3	4.8

Table 3.4 shows that 3% of the women were raped once while 3% were raped more than once. The proportion of men admitting to raping a non-partner was higher than the proportion of women reporting being raped by a non-partner. The survey observed a similar finding in Gauteng, Limpopo and KZN. It would be interesting to know why a greater proportion of men compared to women disclose perpetration of rape. A possible explanation that would need validation is that, in these communities, being raped is considered a shameful thing and, in most cases, the victim is blamed. Thus women would be reluctant to speak out. We explore this further in Chapter 4 of this report.

In the study, a tenth of men said they had raped a non-partner at least once in their lifetime. Five percent of the men admitted to raping more than once. There is a need for stringent measures against men who rape in order to prevent initial and repeat perpetration. Almost half (eight) of the women who shared their "I" Stories experienced rape at the hands of non-partners.

Sexual harassment



The SADC Protocol on Gender and Development defines sexual harassment as 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, whether or not such sexual advance or request arises out of unequal power relations. The South African government enacted the Protection from Sexual Harassment Act (Act 17 of 2011) on the 27th of April 2013. The Act is designed to give effect to some of the most fundamental human rights contained in the Constitution of the Republic of South Africa, 1996 (the Constitution). It affords victims of harassment an effective remedy against such behaviour and introduces measures that will enable the relevant organs of state to give full effect to the provisions of this Act. The Act stipulates that any person who alleges that he or she is being subjected to harassment (as defined) to apply to a Magistrate's Court for a protection order against harassment.

Researchers asked women participating in this study about experiences of sexual harassment in the workplace, schools, whilst using public transport and when seeking help from traditional healers.

Figure 3.9: Sexual harassment experiences by women in a lifetime

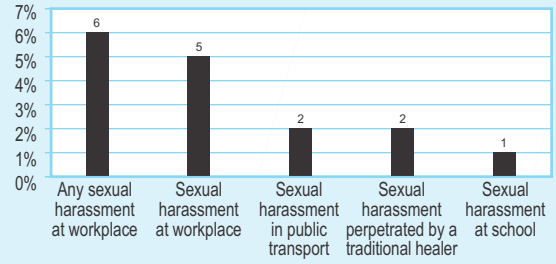


Figure 3.9 shows that 6% of the women experienced some form of sexual harassment in their lifetime. The most common form of sexual harassment experienced by women occurred in the workplace. One in every twenty (5%) of the women who had ever worked suffered sexual harassment in the workplace. The lowest proportion (1%) of sexual harassment occurred in school. Two percent of women were sexually harassed in public transportation. These figures were relatively low in comparison with the findings from Gauteng, Limpopo and KZN studies.

Extent of underreporting GBV in lifetime

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

Table 3.5: Extent of reporting GBV in a lifetime

Criteria	%
Proportion of all women who were physically abused and who reported abuse or threats to police in lifetime	2.6
Proportion of all women who were physically abused and who reported abuse or threats to medical doctor in lifetime	1.4
Proportion of all women who were raped and reported incident to police in lifetime	1.6
Proportion of all women, who were raped and reported incident to medical doctor in lifetime	0.9

Table 3.5 shows that the women underreported violence. Only 2% of women who were raped reported the rape to police while only 1% reported to a medical doctor. This indicates critical underlying problems in the province that need to be explored. Women find it difficult to report violence in societies where survivors are stigmatised and blamed while perpetration of violence is legitimised or ignored (Bott, 2005). In most cases, sexual harassment is trivialised and victims are taken as lacking a sense of humour.[19]

Figure 3.10: Comparison of actual experience prevalence and reported GBV in a lifetime

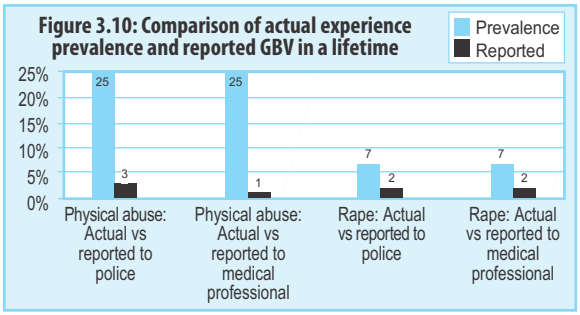


Figure 3.10 shows that the extent of reporting to the police and medical health provider was lower than the extent of physical and non-partner rape. There was a significant underreporting of GBV experience to police or health services. Three percent of the women who were physically abused, reported the incident to the police while 1% of the women reported to the medical health care providers. In order to address the challenges of underreporting, it is imperative to understand the reasons why victims do not report either to the police or health service providers.

GBV in past 12 months

Researchers asked women and men participating in the study who reported ever experiencing or perpetrating GBV, whether their experiences or perpetration had occurred in the 12 months prior to the survey.

[19] Gender Links, 2014, Regional Barometer.

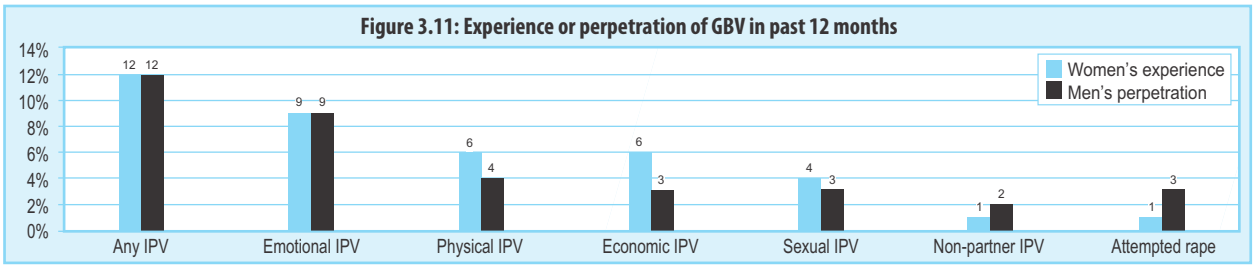


Figure 3.11 shows that IPV was the most common form of GBV followed by attempted rape and non-partner rape in the 12 months prior the survey. Twelve percent of the women experienced, while 12% of men perpetrated, IPV in the 12 months prior the survey. Emotional violence was the most common form of IPV while sexual violence, the least. The same proportion of women (9%) and men (9%) had experienced and perpetrated IPV respectively. Six percent of the women experienced physical abuse and economic abuse. More women reported experience of physical, economic and sexual abuse while a lower proportion of men reported perpetration of these various forms of abuse.

One percent of the women respondents were raped by non-partners in the 12 months before the survey while the same proportion of men (1%) raped women they were not romantically involved with during the same period. Three percent of the men admitted attempting to rape a non-partner in the 12 months prior to the survey.

Extent of reporting GBV in past 12 months

We asked women who reported experience of physical IPV and rape in the 12 months before the survey whether they reported the incidents to the police or health facility.

Table 3.6: Extent of reporting GBV in past 12 months

Criteria	%
Proportion of all women who were physically abused and who reported abuse or threats to police in past 12 months	1.4
Proportion of all women, who were physically abused by partners, injured and sought medical attention in past 12 months	1.6

Table 3.6 shows that, as with reporting in lifetime experiences, the majority of women did not report their experiences of violence in the last 12 months to police and medical health care providers. One percent of the women who were physically abused or threatened by partners reported the incident to the police while 2% of these women reported to medical providers.

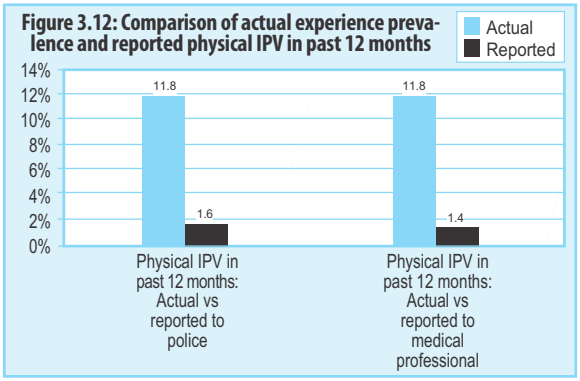


Figure 3.12 shows that reporting of violence was very low. However, a slightly higher proportion of women reported physical abuse to a medical doctor than to the police. This suggests that there is an urgent need to explore factors that hinder women from reporting. Physical IPV and sexual coercion have serious negative consequences on sexual reproductive health of women (Bott, 2005).

Conclusion

The findings presented in this chapter confirm that GBV is prevalent in the Western Cape Province and should receive urgent attention. As we saw in Gauteng, Limpopo and KZN, the dominant forms of violence

occur within the domestic domain. Emotional IPV records the highest prevalence rates. These findings give insight to the magnitude of violence in the province. There is need to focus on prevention strategies based on these findings. Policy makers need to give adequate attention to the domestic domain where much of the violence is occurring. Interventions should seek to address the root causes of violence in both the public and private domains. In this way, we can prevent GBV. Despite the high prevalence of violence when compared to international standards, women are not reporting their experiences of violence to the police and medical health providers. The findings of research done elsewhere indicate that IPV is not reported to the police because women felt the police would not adequately resolve the challenge of violence they were faced with (Tjaden, 2000).

There is a need to educate the community to treat violence against women, especially IPV, as a major social problem. The community and individuals need to be encouraged vigorously to change the attitudes that promote the culture of silence. We need further research to understand the factors that promote under-reporting of violence.

CHAPTER 4
DRIVERS OF GBV



Individual, community and societal factors influence GBV perpetration or experience Take Back the Night Mosselbay Summit Study Visit, Western Cape, South Africa.
Photo: Ntombi Mbadlanyana

Key facts

- During the 12 months prior to the survey, young women aged 18-29 years were more likely to experience IPV than older women.
- A significantly higher proportion of young men (18-29 years) perpetrated IPV than did older men (30+).
- A significantly higher proportion of men who did not matriculate abused their intimate partners in their lifetime.
- A significantly higher proportion of men who did not matriculate raped a non-partner in the 12 months before the survey.
- Eighteen percent of men who had worked during the 12 months prior to the survey and 11% who had not worked during that period, admitted raping a non-partner in their lifetime (p=0.02).
- A significantly higher proportion of men who used drugs perpetrated IPV in the 12 months prior the survey.
- A significantly higher proportion of men who were victims of childhood neglect and childhood sexual and physical abuse committed IPV.
- A significantly higher proportion of men who were victims of sexual abuse and neglect in their childhood admitted to committing non-partner rape compared to men who did not experience such abuse.
- Conservative community norms towards gender relations trigger violence against women.



"My name is Mary-Ann. I grew up in what I considered a normal family. My mother was a nurse, my father a general labourer and I had three brothers and four sisters. I never realised that my mother was a victim of abuse as I grew up. She was a proud and devout Catholic woman and she never complained about the abuse as she suffered in silence.

Most of my relationships with men turned out to be abusive ones and because of my mother's experience, I also learned to suffer in silence. My now ex-husband was emotionally, mentally, verbally, sexually and financially abusive. Even after the divorce, the abuse didn't stop and I left Cape Town to get away from him. I managed to get a protection order after two years, only because I had witnesses who had testified to his abusive nature.

Three years later, I met another man who was loving, caring and went to church. We got engaged and planned to marry. I saw the warning signs of his abusive nature during my pregnancy but then I felt I had to stay because of the baby.

He started drinking excessively and using drugs. In his intoxicated state, he would trash the house, push and shove me, pull me by my hair and deprive me of food, money and sometimes a bed to sleep on. Yet I still made excuses for him, blaming myself and thinking if I did this or that better he would stop abusing me. The sad part is that I started believing all the lies he told me about myself. I became depressed and I stopped taking care of myself and my unborn baby.

I became suicidal. Despair, anger and resentment started to consume me. I was angry with God and with myself. But most of all, I was angry and hated him. In fact, I hated him enough to kill him. I would lie awake at night planning how I would kill him. The more I thought about him, the more I became obsessed with the idea of killing him.

One day, I cut up sheets to use as ropes to tie him up in his drunken state and suffocate him with a pillow. As I was doing this a voice inside of me asked, 'What are you doing? Do you want to end up raising your child in jail? How can you allow this man to destroy you without even putting up a fight? There are other options, get out and get help.'

I left the house with only the clothes on my back and ended up at a crisis centre for pregnant women. By this time, I had no self-esteem and didn't know how I was going to raise my child so I considered adoption. I eventually put my baby up for adoption thinking that it would be better for him. I felt so miserable without him.

How could I allow this man to ruin and rule my life to the point I let my first child go? The one and only time I saw my baby, something inside of me changed and I felt hope.

This child of mine gave me hope for the future. Two weeks after he was taken away, I withdrew my consent for adoption and six weeks later, he was back in my arms. Without my son I wouldn't be a stronger and healthier mother and woman. Because of him I wanted to be better so that I can raise a healthy and happy boy.

But most of all I want to do it for my own health and safety."

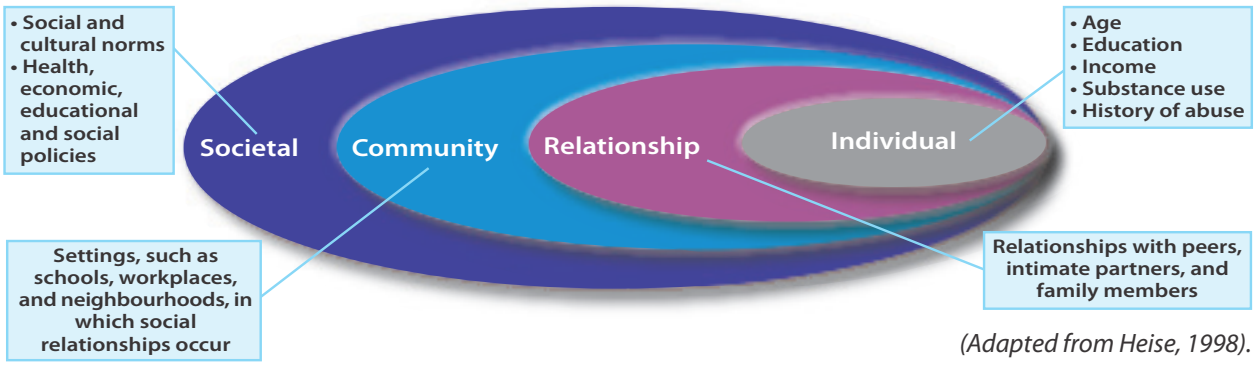
Being a witness or survivor of violence in the early years of life increases the risk of being a victim in the later years. Mary-Ann saw her mother suffer domestic abuse in silence. She internalised and normalised her mother's experiences so that when she encountered the same challenge, she also suffered in silence. She suffered physical, emotional, sexual and economic abuse from her husband. Her story shows that one's childhood experiences as well as the family setup can influence violence.

This chapter looks at the various risk factors that influence victimisation and perpetration of violence in the Western Cape community. Gender violence is influenced by a multitude of factors (Suffla, 2006). The ecological framework (Figure 4.1) conceptualises violence as a complex phenomenon resulting from

an interplay of personal, situational and socio-cultural factors (Heise, 1998). Understanding the reasons for and the factors associated with experience or perpetration of gender violence is a precursor in the design of GBV prevention interventions.

The ecological model in Figure 4.1 is a theoretical framework that explains why some of the violence occurs, why some men are more violent than others and why some women are consistently the survivors of abuse (Heise, 2002).

Figure 4.1: The ecological model of factors associated with VAW



(Adapted from Heise, 1998).

According to the ecological framework, interpersonal violence results from interactions at the individual, relationship, community and societal levels. The inner circle represents the individual level where personal history and biological factors influence how an individual's behaviour is likely to increase their likelihood of becoming a victim or a perpetrator of violence.[20] The framework postulates the relationship level as the second circle, which illustrates the context in which gender violence occurs. Interactions with family members, intimate partners and friends can also influence the risk of gender violence. The third circle represents the community level where informal and formal structures such as the neighbourhood, workplace and school influence the risk of violence. The outer circle represents the societal levels where social, economic and cultural factors trigger or inhibit violence. For example, cultural norms in patriarchal societies have been found to trigger violence (Strebel, 2006).

This study uses the framework to explain the experience and perpetration of violence among the participants.

[20] http://www.who.int/violenceprevention/approach/ecology/en/

Socio-demographic factors

The socio-demographic characteristics researchers explored include age, education level, employment status, childhood abuse and substance use.



Table 4.1: Socio-demographic factors associated with experience and perpetration of IPV								
Factors	Ever IPV				Past 12 months IPV			
	% women survivors	Chi(p)[21]	% men perpetrating	Chi(p)	% women survivors	Chi(p)	% men perpetrating	Chi(p)
Age								
18-29	44.7	0.19	41.4	0.26	17.6	0.002	19.9	0.0002
30-44	46.9		36.9		15.3		10.8	
45+	38.7		31.4		4.6		3.5	
Level of education								
High school incomplete and lower	47.6	0.17	42.4	0.02	13.1	0.47	13.8	0.31
High school complete and over	39.9		32.2		10.7		10.1	
Worked in past 12 months								
No	43.2	0.87	39.1	0.39	10.4	0.17	13.1	0.21
Yes	43.9		35.0		13.6		10.5	

Age

Table 4.1 shows no statistically significant difference in the proportion of IPV survivors by age. This implies that women all of ages are equally vulnerable to IPV. However, there was a statistically significant difference in the proportion of IPV survivors by age during the 12 months prior the study. Experience of IPV among women decreased with an increase in age. Eighteen percent of the young women aged 18-29 years experienced IPV while 5% of women aged 45 and older experienced IPV. There was a significant difference in perpetration of IPV among the men, with the highest proportion of perpetration being among young men aged 18-29 and the lowest among men who were 45 years and older 12 months before the study.

Education level

A significantly higher proportion of men who had not completed high school perpetrated IPV in their lifetime compared to the men who had completed high school. Forty-two percent of the men who did not complete high school perpetrated IPV in their lifetime while 32% of men who completed high school perpetrated IPV in the similar period. The differences in the prevalence of IPV experience according to level of education among women in lifetime and 12 months prior the survey are not statistically significant.

Employment status

There was no significant difference in the experience or perpetration of IPV based on employment status in the 12 months before the survey and in lifetime. This implies that both the employed and unemployed are almost equally susceptible to the experience or perpetration of abuse.



[21] Pearson Chi Square Test is a statistical test used to test association to sets of categorical data-to evaluate how likely it is that any observed difference between the sets arose by chance.

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	5.6	0.39	15.7	0.81	2.2	0.14	2.6	0.22
30-44	5.8		15.7		1.2		1.8	
45+	8.5		13.5		-		-	
Level of education								
High school incomplete and lower	0.8	0.20	14.2	0.68	0.8	0.20	2.3	0.07
High school complete and over	1.2		15.7		1.2		0.9	
Worked in past 12 months								
No	0.9	0.78	10.7	0.02	0.9	0.77	0.73	0.25
Yes	1.1		18.0		1.1		2.1	

Age

Table 4.2 shows no statistically significant difference in the proportions of women who were raped in the different age groups in lifetime experiences or during the 12 months prior the study. Similarly, there was no statistically significant difference in the proportion of rape perpetrators in the different age groups in lifetime experiences or the 12 months before the survey.

Education

Education was not associated with men's perpetration of non-partner rape in both lifetime and in the 12 months before the survey period ($p>0.05$).

Employment status

A significantly higher proportion (18%) of men who had worked 12 months prior to the survey admitted ever raping a non-partner. There was no significant employment status difference in proportions of non-partner rape survivors in lifetime experiences or during the 12 months prior the study.

Alcohol and substance abuse

Alcohol and substance abuse is associated with increased risk of IPV (Jewkes et al, 2002; Mckinney, 2010). This study looked at the links between alcohol and substance abuse and perpetration of GBV. Questions relating to alcohol and drugs included whether the respondent had taken alcohol in the 12 months to the survey and if the response was yes, then how often. The survey also asked participants whether their current or most recent partner consumed alcohol and how often they did this. Questions on substance use included whether the respondent or their partner used drugs and how often they did this.

> Christal says: *"The abuse started when he started using drugs like tik, mandra, dagga and alcohol. I was pregnant at that time and he would slap me or force me to have sex with him."*

Table 4.3: Alcohol and drug consumption patterns by women and men		
	% women	% men
Have you consumed alcohol in past 12 months		
No	68.3	41.4
Yes	31.7	58.6

	% women	% men
How often do you take a drink containing alcohol		
Monthly or less	39.6	33.2
2-4 times a month	40.3	47.5
2-4 times a week	14.2	13.9
4+ times a week	5.9	5.5
More than five drinks on one occasion		
Never	26.7	13.1
Less than monthly	27.3	21.4
Monthly	26.4	37.9
Weekly	16.3	25.4
Daily or almost daily	3.3	2.2
Current partner alcohol frequency		
Every day/nearly every day	7.0	1.3
Only at weekends	25.5	12.1
A few times in a month	17.2	10.0
Less than once a month	5.3	6.4
Never drank	44.8	69.8
Stopped drinking	0.2	0.5
Current or most recent partner drug use		
No	96.9	96.7
Yes	3.1	3.3

Table 4.3 shows that 59% of the men and 32% of the women drank alcohol. A higher proportion of men were binge drinkers (87%), drinking more than five alcoholic drinks on one occasion. A quarter of the men drank more than five alcoholic drinks on one occasion on a weekly basis whereas 2% drank that amount on a daily basis. Sixteen percent of the women drank more than five drinks on one occasion on a weekly basis. More than a quarter (26%) of the women had a partner who drank alcohol only at weekends whereas 7% of the women had a partner who drank every day or nearly every day. An equal proportion (3%) of the women and men had intimate partners who used drugs. This supports findings that the South African society has high alcohol consumption (Jewkes, 2010), especially in Western Cape, and as confirmed by the "I" Stories.

Table 4.4: Partner alcohol or substance use and experience of IPV in past 12 months

	% women survivors in past 12 months	Chi(p)
Partner drank alcohol	17.9	0.000
Partner did not drink alcohol	5.4	
Partner used drugs	44.6	0.000
Partner did not use drugs	11.0	

Table 4.4 shows that the women with a partner who used drugs or drank alcohol were more likely to be survivors of IPV in the 12 months before the survey. Eighteen percent of the women whose partner drank alcohol and 5% of women whose partners did not drink alcohol reported experiencing IPV during the

12 months before the study. Forty-five percent of women whose partner used drugs while 11% percent of women whose partners did not use drugs reported experiencing IPV during the 12 months before the study. Previous studies in the Western Cape show a similar association between alcohol abuse and perpetration/experience of gender violence (Strebel, 2006).

This calls for the reviewing and strengthening the Western Cape Liquor Act of 2009 which aimed at regulating liquor outlets and reducing alcohol consumption in the province. More stringent penalties need to be put in place as a restrictive measure.

There are other factors, such as poverty, that exacerbate the association between alcohol use and gender violence (WHO, 2001). There is need to identify the factors which increase the risk of perpetration of violence so that additional appropriate interventions can be put in place.

Table 4.5: Alcohol or drug use and perpetration of IPV in past 12 months

	% men perpetrators in past 12 months	Chi(p)
Drank alcohol	12.3	0.68
Did not drink alcohol	11.1	
Used drugs	19.3	0.002
Did not use drugs	8.0	

Table 4.5 shows that the difference in IPV perpetration among men who drank and those who did not drink alcohol was not statistically significant. However, there was a significant association between drug use and IPV perpetration. Nearly a fifth of men who used drugs compared to 8% of men who did not use drugs committed IPV in the 12 months before the survey.

The current study is not the only one to establish association between drug use and gender violence in the Western Cape. The Western Cape Government's Integrated Provincial Violence Prevention Policy Framework also identified alcohol consumption as a risk factor of both the experience and perpetration of violence. Therefore, one of the strategies proposed in the policy is reducing the availability and harmful use of alcohol.

The government acknowledges that alcohol lowers inhibition and fuels aggressive behaviour and violence. Alcohol also contributes to the lowering of reflexes, motor skills and cognitive perception so that intoxicated people are more likely to become victims of violence. In 1999, 62% of murdered women in the Western Cape had elevated blood alcohol concentrations at the time of death.[22] The government passed the Western Cape Liquor Act of 2009 which came into effect from April 2012. The Act regulates liquor outlets and, inter alia, aims to limit access to alcohol in residential areas.

The government also embarked on an intervention aimed at closing down all illegal shebeens. It is estimated that in 2013 there were about 25 000 illegal shebeens in the Western Cape. Only the SAPS has the power to close down illegal shebeens, particularly in crime hotspot areas.[23]

Child abuse

Child abuse is defined as any interaction or lack of interaction by a parent or caretaker that results in non-accidental harm to the child's physical and/or developmental state.[24] This term includes not only the physical, non-accidental injury of children, but also emotional abuse, sexual abuse and neglect.[25]

Research has found strong associations between childhood abuse and violence against women (Abrahams, 2005).

[22] http://www.westerncape.gov.za/news/western-cape-government-launches-violence-prevention-policy
[23] http://www.westerncape.gov.za/news/western-cape-government-launches-violence-prevention-policy
[24] http://www.childlinesa.org.za/index.php/documents-for-download/doc_download/197-recognising-child-abuse
[25] http://www.childlinesa.org.za/index.php/documents-for-download/doc_download/197-recognising-child-abuse

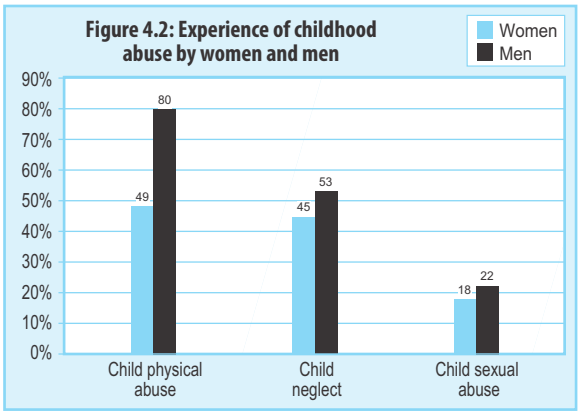


Figure 4.2 shows the most prevalent form of childhood abuse among the women and men was physical abuse, and that sexual abuse was least prevalent. A higher proportion of men (80%) than women (49%) had experienced childhood physical abuse. Childhood physical abuse in this study includes corporal punishment[26] which is deeply embedded the South African culture both in schools and at home. Forty-five percent of the women and 53% of men suffered neglect as children. Eighteen percent of women and 22% of the men suffered sexual abuse during childhood years. More men than women experienced the various forms of childhood abuse. This shows that the formative years of both men and women are characterised by abuse that resurfaces in adulthood with women as victims and men as perpetrators.

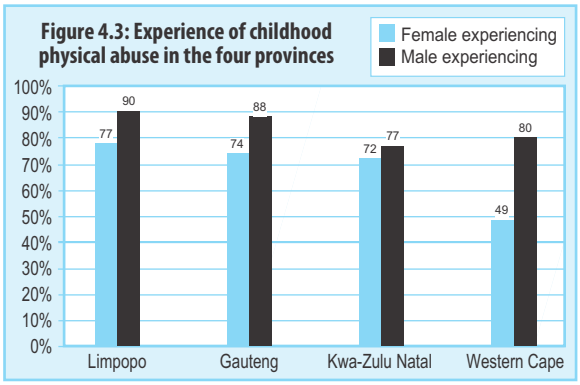
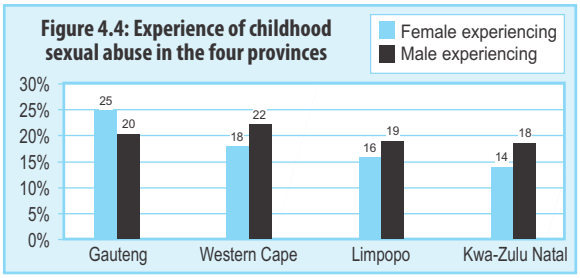


Figure 4.3 shows the prevalence rates of childhood physical abuse across the four provinces. Among the women who participated in this study, 77% of the women from Limpopo, 74% from Gauteng, 72% from KZN and 49% from the Western Cape disclosed that they experienced physical abuse in their childhood. Similarly higher proportions of men (90% in Limpopo, 88% in Gauteng, 77% in KZN and 80% in Western Cape) experienced physical abuse in childhood. Across the four provinces is the fact that higher proportions of men compared to women experienced childhood physical abuse. Western Cape has the largest gap between the men and women who experienced this abuse.

These figures show that physical abuse is rife in these provinces. Recently, there has been a heated debate around the issues of child physical abuse and corporal punishment. Two arguments have arisen over the years. One argument contends that corporal punishment is not bad if done without necessarily inflicting pain and without causing physical or emotional damage.[27] However, UNICEF and other parties believe that prohibition of all forms of violence against children, including corporal punishment, is necessary to break the cycle of violence in communities.[28] While this is a debatable issue requiring more empirical research, it should be noted that there are many ways of disciplining children without being violent. Studies show that children learn through assimilation and accommodation. Physical violence that they experience in their immediate social environments can easily be internalised and normalised, making them perpetrators of violence later in life.



[26] Corporal punishment involves a deliberate act that inflicts pain or physical discomfort in order to punish someone. www.erp.org.za/htm/issuepg_punish.htm
[27] Savethechildren.org.za/sites/south_africa/files/Topic-Corporal Punishment that is NOT Cruel, Inhuman or Degrading.pdf#overlay-context=users/rodneyknotts
[28] www.iol.co.za/lifestyle/family/kids/why-corporalpunishment-doesn-t-work-1.1563490#.UvohL7RyOuY

Msanyoki says: *"My uncle took me to his daughter Flora's house. Flora was older than me. She stayed with me and cared for me as if I was her own child, but at the end she had this bad mind and she forced me to sleep with her. She said that if I refuse her then I must get out of her house and never come back. Then because I was desperate and had nowhere to go I slept with her and she told me not to tell anyone."*

Figure 4.4 shows the rates of childhood sexual abuse experienced by both women and men who participated in the study. A quarter of the women participants in Gauteng, 18% in the Western Cape, 16% in Limpopo and 14% in KZN reported that they experienced sexual abuse in childhood. Similar to the findings on childhood physical abuse, generally a higher proportion of men compared to women reported having experienced childhood sexual abuse in Western Cape (22%), Limpopo (19%) and KZN with 18%. There is need for further research to understand why more men than women were victims of violence.

Studies in several different settings have identified girls as being at greater risk of experiencing sexual abuse than boys.[29] It would also be interesting to establish a profile of the perpetrators of these offences. The most common finding is that the majority of sexual offenders are family members or otherwise known to the child.[30] Of the women and men who shared their personal accounts, most had experienced childhood sexual abuse at the hands of family members. Some scholars argue that adolescents are at a greater risk of experiencing sexual abuse than young children, partly because their physical developments make them more attractive (Bills, 2005).

Figure 4.5: Childhood trauma factors associated with perpetration of IPV

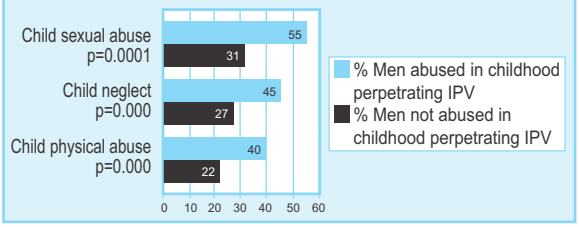


Figure 4.5 shows that childhood abuse is associated with IPV perpetration by men. A higher proportion of men who were sexually and physically abused and neglected as children admitted that they had committed IPV.

This calls for violence prevention strategies not to focus only on the girl child but to include boys as well. We should be directing attention at preventing child abuse of both female and male children.

There is a need to teach communities about creating safe and happy environments for children to grow. Gender violence sensitisation should start in childhood especially in males so that they grow up with gender attitudes that minimise the use of violence.

Figure 4.6: Childhood trauma factors and perpetration of non-partner rape

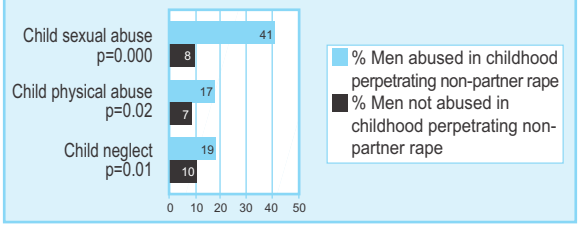


Figure 4.6 shows there was an association between childhood neglect, physical and sexual abuse and non-partner rape. Men who experienced abuse in childhood were more likely to rape non-partners than men who did not experience abuse in childhood. Forty-one percent of men who were sexually abused in childhood and 8% of men who were not sexually abused in childhood raped a non-partner. These findings confirm the existing literature. According to Johnson et al. (1999), witnessing family violence increases the likelihood of perpetrating IPV. Similarly in Harrison and Associates' (1999) study, 62% of women who reported childhood abuse experienced domestic violence in adulthood. There is an emerging consensus that child and adolescent sexual abuse has lasting consequences for emotional and physical wellbeing.

[29] David Bells, 2005, The shape of social inequality: Stratification and ethnicity in comparative perspectives.
[30] www.apa.org/pubs/info/brochures/sex-abuse.aspx?item=3

Gender relations

Gender relations in South Africa are predominantly characterised by power inequalities. Traditional gender roles dictate that women should be submissive to men (Strebel, 2006). As such, the low status of women in society makes them vulnerable to violence because men possess and exercise the control and power they have in the domestic spheres.

Gender attitudes that support male supremacy trigger violence against women (Abrahams et al, 2006; Jewkes et al, 2002). Thus, women who challenge male dominance or undermine male authority in the home are at high risk of experiencing IPV (Strebel, 2006). Research has also shown that women who lack empowerment and do not have a say in family matters are more likely to experience IPV than those who are empowered (Strebel, 2006).

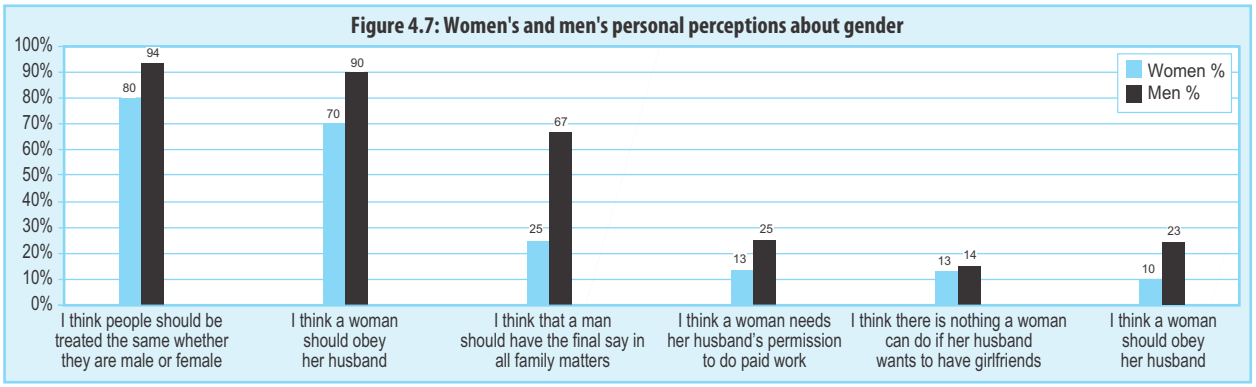


Figure 4.7 shows that the perceptions of men are more traditional and conservative than the perceptions of women. Seventy percent of women and 90% of men believed that a woman should obey her husband. Nearly seven out of ten (67%) men compared to a quarter of women thought a man should have the final say in family matters. This implies that men are still holding on to the gender roles set by society that most women are castigating. On a more positive note, high proportions of women (80%) and men (94%) believed that females and males deserve equal treatment. However, the more conservative responses to the other statements, contradict this.

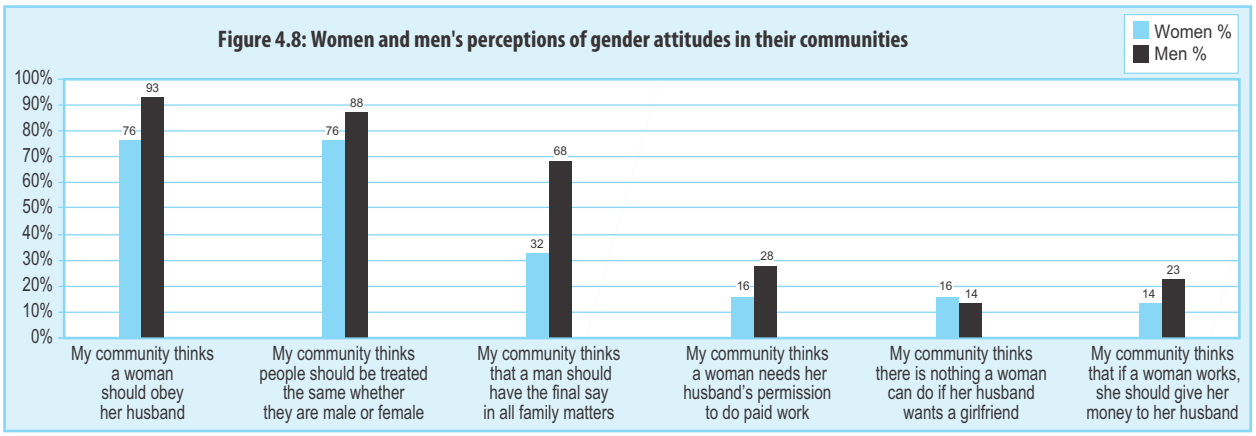


Figure 4.8 shows the gender perceptions that the women and men had of their community. More than three quarters (76%) of women and 88% of men felt the community believed that a woman should obey her husband. A higher proportion of men than women perceived their community felt that a man should have the final say in family matters. More men (93%) than women (76%) perceived that their communities supported equality between women and men.

Pam says: *"He started beating me and said he did it because he loved me…" ~ One of the myths found in societies: that beating a wife shows love.*

Sexual entitlement in marriage and legitimacy of violence

Ideologies of sexual entitlement in marriage expect women not to refuse sexual advances from their husbands. The notion of equating payment of *lobola* with purchasing property and wife "ownership" impacts on sexual relations and the manner in which sex is negotiated between partners. These conservative attitudes trigger VAW.

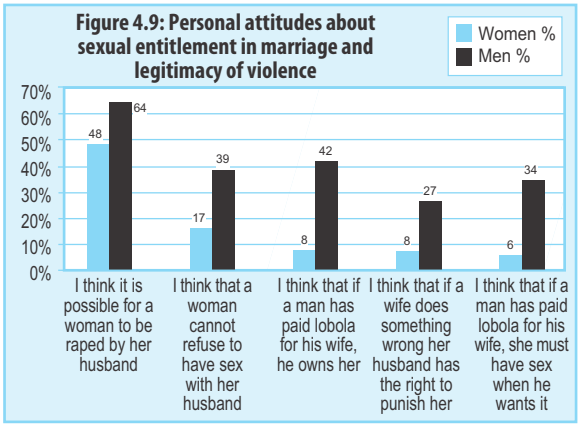


Figure 4.9 shows more men than women felt a husband was entitled to sex and control in marriage. Men who hold such conservative views are more likely to commit IPV (Jewkes et al, 2002). Thirty-nine percent of men compared to 17% of women thought a woman cannot refuse her husband sex. About four out of ten (42%) men compared to 8% of women perceived that payment of lobola meant a husband owns his wife. More men (27%) than women (8%) agreed with the use of violence as a form of punishment by a husband on his wife. Compared to the other three provinces where the study was done, it is commendable that women in Western Cape are more progressive and do not reinforce inequitable gender norms as much as the women in other provinces.[31] (Gender Links baseline studies).

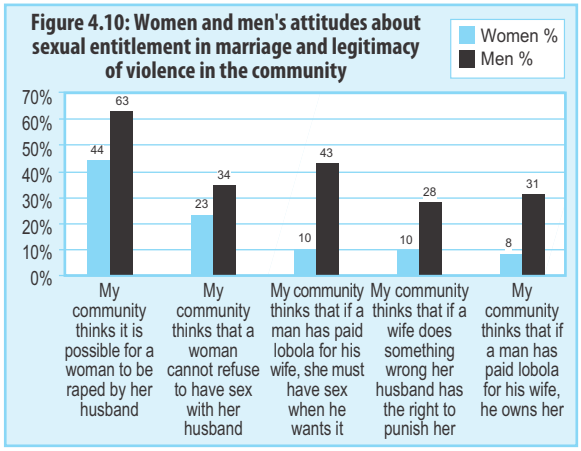


Figure 4.10 shows more men than women felt that their communities thought a husband has sexual entitlement in marriage and that he can use violence as a means of punishment. Thirty-four percent of men compared to 23% of women believed that the community thought that a woman cannot refuse to have sex with her husband. Forty-three percent of men and a tenth of women perceived that the community thought if a man paid lobola for his wife, he owned her. Twenty-eight percent of men and 10% of women believed their community agreed a husband could use violence to punish his wife. Such conservative attitudes towards sexual entitlement and punishment trigger gender violence among men.

[31] Gender Links, GBV Baseline studies.

Societal

The Southern African Development Community (SADC) Protocol on Gender and Development, signed in August 2008, calls on member states to halve gender violence by 2015. Specific measures outlined in the Protocol include legislation, where appropriate, to discourage traditional norms including social, economic, cultural and political practices, which legitimise and exacerbate the persistence and tolerance of gender violence. This is with a view to eliminating such practices in all sectors of society, as well as introducing and supporting gender sensitisation and public awareness programmes aimed at changing behaviour and eradicating gender-based violence.

Reaching the goals set out in the SADC Protocol will require member states to take concrete action - with political will as the lynchpin of any progress. Change will only happen if it is accompanied by strong and committed leadership that prioritises ending gender violence and places the issue high on regional and national agendas. What leaders say greatly influences public perceptions, attitudes and behaviour. Political discourse is a powerful tool for disseminating values and information, educating and raising awareness. It is also a measure of levels of state commitment and accountability.

Over the past two years, the Western Cape has been in the spotlight in both the media and political speeches because of the widely publicised murder of Anene Booysen that got the whole nation talking. Seventeen-year-old Anene Booysen of Bredasdorp in the Southern Cape, was gang raped and badly mutilated.

Excerpt from the Daily Maverick article: *President Jacob Zuma said the attack on Booysen was "shocking", "cruel" and "inhumane" and called for the harshest possible sentence for the assailants. "Impose the harshest sentences on such crimes, as part of a concerted campaign to end this scourge in our society," said Zuma in a statement. "It has no place in our country. We must never allow ourselves to get used to these acts of base criminality to our women and children." The president's statement was one of a volley of reactions from government, opposition parties, civil society groups, women's rights organisations and organised labour, expressing outrage and demanding action to stem the tide of sexual violence in South African society. Cabinet has now decided to prioritise crimes against women and children and wants there to be no bail for suspects and stiffer sentences. The ANC Women's League wants an official enquiry into gender-based violence. "We will be calling for a national commission of enquiry into rape and gender-based violence in order to develop a national strategy to eradicate rape from South African society," the league said.*[32]



President Jacob Zuma attends Western Cape Mass Prayer meeting, 2014.
Photo: https://www.flickr.com/photos/governmentza/14080464143/

[32] Ranjeni Munusamy, Daily Maverick: The agony of South Africa's daughter Anene Booysen. The agony of South Africa. http://www.dailymaverick.co.za/article/2013-02-08-the-agony-of-south-africas-daughter-anine-booysen-the-agony-of-south-africa/#.U9Y12rHeKuY 8 February 2013.

Figure 4.11: GBV mentions in political discourse

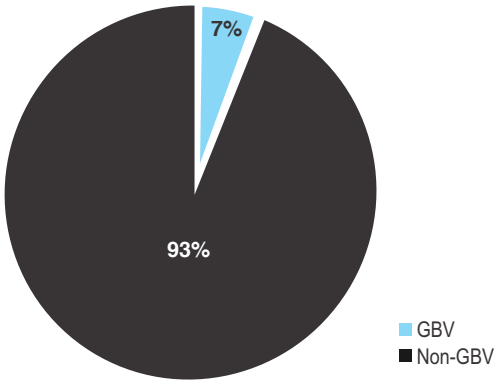


Figure 4.11 illustrates that of the 2 238 political speeches collected from April 2010 to March 2011, only 7% referred to GBV. This indicates that politicians gave scant attention to the important issue of GBV. By speaking more frequently about GBV, the country's political leadership could play a highly effective role in sensitising society to this social ill.

Figure 4.12: GBV mentioned as main topic

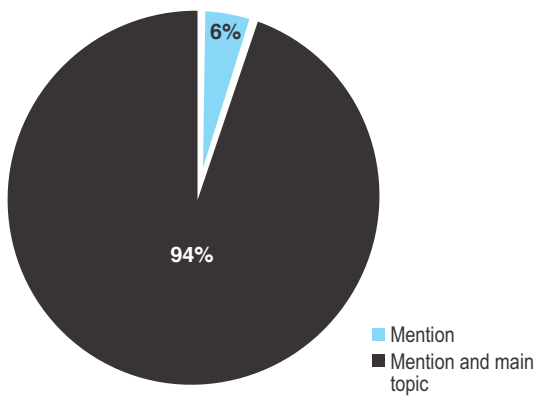


Figure 4.12 shows that of the 154 speeches that referred in some way to GBV, only 6% addressed gender violence as a main topic. This indicates that an overwhelming majority of the speeches that included GBV, incorporated mention of it only as a passing reference. This illustrates that South Africa's political leaders have been failing to demonstrate a holistic knowledge about the extent and causes of gender violence or substantial information about prevention measures and support structures.

Figure 4.13: GBV speeches by occasion

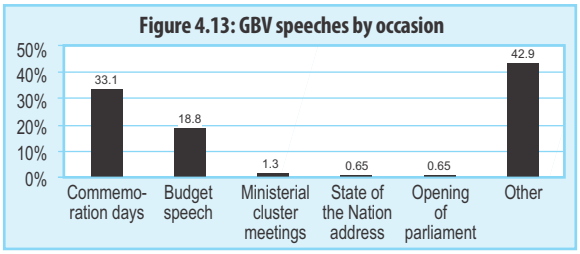


Figure 4.13 illustrates that most political speeches that mentioned GBV (43%) fell into the "other occasion" category. This includes the release of the National Crime Statistics and the launches of various services and victim empowerment events. This seems to indicate that politicians address GBV throughout the year and not only on special, commemorative occasions. Speeches mentioning GBV presented during commemorative days such as the 16 Days of Activism, World Aids Day and Women's Day accounted for about a third (33%) of all speeches. Nearly one in five speeches (19%) mentioned GBV during budget-related occasions.

Who speaks on GBV?

Cabinet ministers presented more than half (51%) of GBV speeches, while Cabinet deputy ministers spoke in 14% of speeches. Members of Parliament (MPs) mentioned GBV in 9% of speeches while the president addressed GBV in 7% of speeches. This is a clear indication that while the Cabinet is giving some attention to the issue, the president and his deputy did not prioritise gender violence in those speeches given during the review period. Of 154 speeches that mentioned GBV, President Jacob Zuma delivered only 11. Meanwhile, Deputy President Kgalema Motlanthe mentioned gender violence in just two speeches.

Reference to GBV by women and men

Reference to GBV was distributed fairly equally between women and men politicians - women mentioned gender violence in 54% of speeches, while

men addressed the issue in 46% of speeches. These results indicate that women have been giving more attention to the plight of those affected by gender violence.

Who is the target audience?

Politicians addressed other functionaries in 77% of all speeches, followed by general citizens in 60% of speeches. Politicians addressed other MPs in 36% of speeches. It is worth noting that politicians only addressed community members in 15% of all speeches (fewer than two of every 10 speeches). These findings show that political leaders mainly address other politicians in their speeches, which underscores the need for leaders to better target general citizens in order to create meaningful awareness of gender violence in society.

Figure 4.14: Forms of GBV referred to in speeches

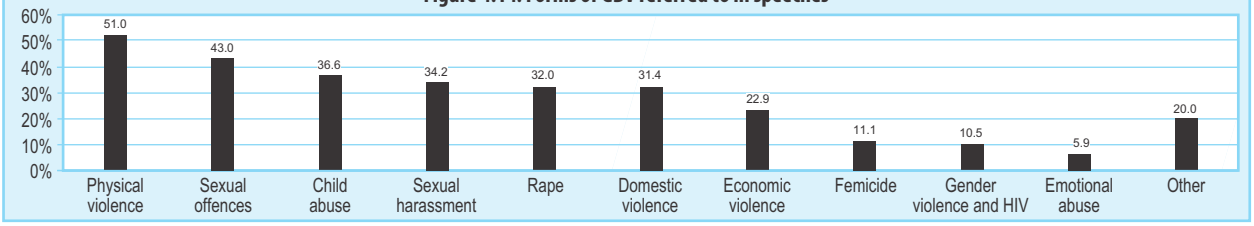


Figure 4.14 shows that politicians mentioned physical violence most commonly as a form of gender violence in half (51%) of all speeches. Politicians mentioned sexual offences and child abuse in 43% and 37% of speeches, respectively. Fewer politicians mentioned forms of GBV such as femicide (11%), the link between gender violence and HIV (11%) and emotional abuse (6%). It is worrying that emotional abuse received such little attention despite research showing that this is the most commonly experienced form of gender violence for women. By identifying and discussing other forms of gender violence, such as homophobic attacks or men killed in abusive relationships, political leaders can raise awareness about many less-reported forms of GBV.

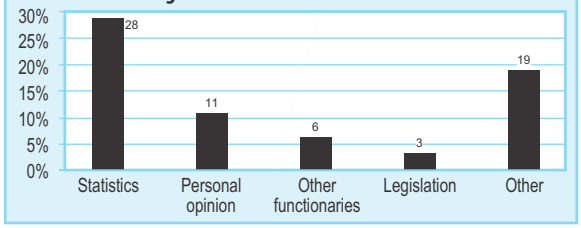
Who speaks on what?

Women and men spoke most frequently about physical violence - in 61% and 39% of speeches, respectively. Female leaders mentioned sexual offences in half (51%) of speeches, while men made such references in 34% of speeches. Women actually spoke more than men about all forms of GBV except those which fall under the "other" category and about rape, which male leaders mentioned marginally more than women (32.8% compared to 32.5% for women).

Reference to extent of GBV by women and men

Only 28% of the speeches referred to the extent of GBV. Furthermore, women (38%) spoke more about the extent of GBV than men (16%). This shows that political leaders have so far failed to provide scope on gender violence, thus making it difficult to fully understand and contextualise the prevalence or even existence of GBV.

Figure 4.15: Data sources on extent



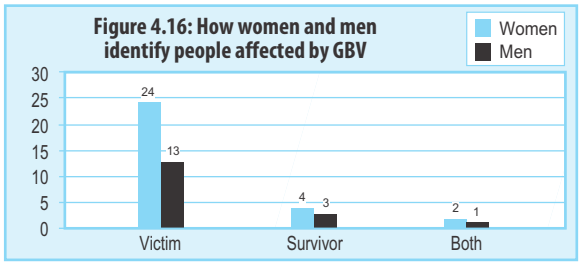
According to Figure 4.15, in 28 speeches politicians used statistics as data source on the extent of GBV. Politicians used their own opinion as source in 11 speeches, while mentioning other functionaries and legislation in six and three speeches, respectively. It is necessary to make use of statistics because this provides the audience with researched and peer-reviewed facts as opposed to personal opinion, which

may not always be informed by research. As Nathi Mthethwa, Minister of Police said, "We have seen a decrease in sexual offences by 4.4% between 2008/09 and 2010/11... this resulted in 26 311 arrests." This type of information provides perspective and hard data for both the public and for service providers.[33]

Frame of reference

Politicians mentioned violence against women and children in more than half (53%) of speeches, making it the most commonly used frame of reference when describing GBV. The second most common was violence against women at 43%. For example, on the occasion of the budget vote, Police Minister, Nathi Mthethwa spoke of the "establishment of specialised units with particular emphasis on violence against women and children." Politicians used the appropriate frame of reference, GBV, in about one in every five speeches (22%). While it is important to acknowledge that women, children and people with disabilities all experience various forms of gender violence, the needs of each group remain different and should be addressed separately. By conflating the issues, the speaker may risk creating the impression that addressing GBV involves the same causes, effects, challenges or prevention measures for women, children and people with disabilities.[34]

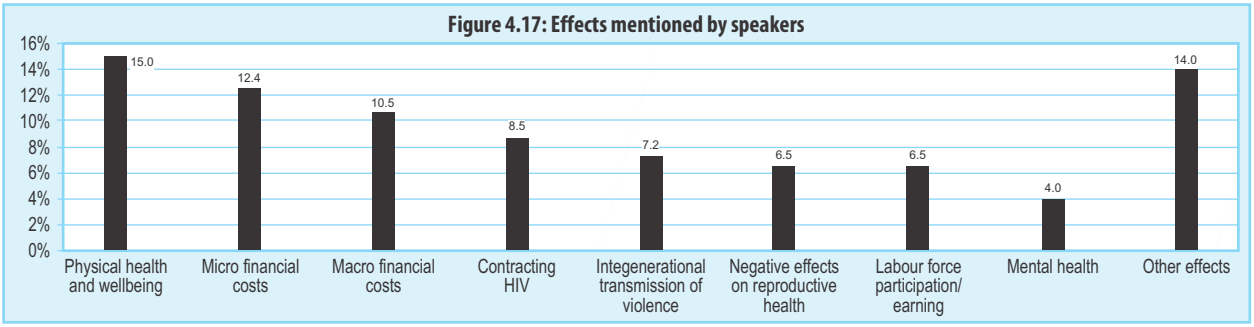
Nearly a quarter of speeches (24%) referred to people affected by gender violence as "victims" while the speakers used the term "survivor" far less frequently (in just 4% of speeches). Figure 4.16 shows women spoke more of victims than did men - 24 occurrences compared to 13 - and women also mentioned survivors more, in four speeches compared to three by men.



Causes mentioned by women and men

Speakers mentioned the causes of GBV in 40% of speeches, of which women mentioned GBV causes in nearly two thirds (58%). Women and men identified societal and other causes most frequently, while both spoke least about community causes. Minister Angie Motshekga said at the closing ceremony of the 16 Days Campaign in 2011: "Male domination is an abomination to humanity. Together we can and must render patriarchy and cultural domination unworkable!"

It remains essential for politicians to address the causes of gender violence in order to show the different levels at which it is created and maintained, be it societal (cultural beliefs) or individual (under the influence of alcohol).



[33] KZN GBV Baseline Study, 2013.
[34] KZN GBV Baseline Study, 2013.
[35] KZN GBV Baseline Study, 2013.

Only 23% of speeches mentioned the potential effects of GBV. This indicates that politicians have not made adequate efforts to identify the numerous ways in which gender violence affects survivors. According to Figure 4.17, the most frequently noted effects of GBV related to physical health and wellbeing (mentioned in 15% of speeches).

Minister Angie Motshekga mentioned such effects at the closing ceremony of Women's Month, noting that "a mother was grievously assaulted with a spade by her husband and admitted to hospital in a critical condition." Politicians mentioned micro and macro financial costs in 12% and 11% of speeches respectively, while they referred to effects on mental health in 4% of speeches. It is crucial that politicians become aware of the various effects of gender violence in order to foster a contextual understanding of the severe consequences of GBV for survivors. Other effects include contracting HIV, inter-generational transmission of violence as well as unwanted pregnancies.

Location of responsibility to end GBV

In addressing the topic, state representatives took responsibility to end GBV in 79% of all GBV speeches. However, speakers placed less responsibility on communities, civil society, family units and individuals. This is unfortunate, because these sectors of society deal most intimately with issues of GBV.

Reference to financial resources required to end GBV

Findings show that a mere 9% of all GBV speeches made reference to financial resources. By failing to mention the fiscal issues linked to GBV, politicians make it difficult for the general public and service providers to understand the costs required to tackle it.

The Tshwaranang Legal Advocacy Centre (TLAC) to end violence against women expressed concern on the 2014 budget speech delivered by the Finance Minister, Pravin Gordhan. According to TLAC, the Minister presented a gender-blind budget, with almost no reference to how women have been disadvantaged, or have benefited, or have had significant improvement to their lives - which ultimately has a positive effect on their families too. The budget according to TLAC is based on a National Development Plan which is as gender blind, and appears to be built on the assumption that all of us are equal and start from the same base. As such, TLAC disagreed with the Minister's statement that "Twenty years of freedom and democracy have changed the face of our country. The last five years have further advanced change and a better life for all, especially the poor and the working class." Violence against women and girls has a direct impact on their right to employment, education and safety. President Jacob Zuma has acknowledged that scourge of violence against women and girls needs to be addressed urgently. Every day we hear how women and girls are robbed of their dignity and their lives, yet our esteemed Minister of Finance was totally silent on the matter. Aside from some allocation to the SAPS that may cover infrastructure, what are the specific resources allocated to dealing decisively with this scourge? The Minister's silence on these matters leaves much to be desired and is a reminder of how South African women are continuously overlooked when it comes to the budget allocation.

Adapted from TLAC's Press Release:
Budget Speech - Minister Gordhan,
Women Do Not Have a Good Story to Tell, 2014[36]

[36] http://www.tlac.org.za/budget-speech-minister-gordhan-women-do-not-have-a-good-story-to-tell/#more-4758 : Accessed 28-07-2014.

Who mentions financial resources required to address GBV?

A total of 14 speeches mentioned financial resources required to address GBV, with cabinet ministers speaking most on this issue in six speeches, followed by MPs who made five mentions. At Budget Vote 7, MP Pat Lebenya-Ntanzi noted: "The new department of women, children and people with disabilities has only been allocated R156 million over a three year period to achieve its goals."

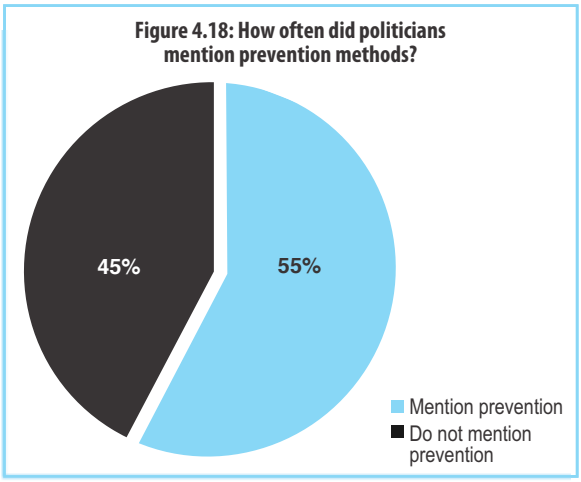


Figure 4.18 shows politicians mentioned prevention measures in more than half (55%) of speeches, with legislative measures most frequently cited in 40% of speeches.

Politicians mentioned campaigns and protests to end gender violence in 33% and 27% of speeches respectively. Fewer mentioned prevention measures such as cyber dialogues on GBV, media coverage and inclusion of GBV in the education curriculum. It is important for politicians to note available prevention measures in order to create awareness about the various ways in which GBV can be averted. During her State of the Province Address, the Western Cape Premier, Helen Zille stated that "there is no other area in the province where the 'whole of society' approach has a more important role to play than in tackling crime and violence." In this speech, she recognises the role of integrated approaches in addressing social ills such as gender violence.[37]

Types of challenges

The findings indicate that political leaders mentioned challenges to addressing GBV in 43% of speeches. Cultural beliefs appeared most often, mentioned in a fifth (21%) of all speeches that mentioned challenges to addressing GBV.

Conclusion

Many interrelated factors, as illustrated by the ecological framework, trigger gender violence. The four circles of the ecological framework also illustrate the various levels of interventions that need to be put in place to effectively reduce the incidence of gender violence in the Western Cape Province. On the societal, community and individual levels, there is great need to eradicate the patriarchal gender attitudes that promote inequality and the subordination of women by men in intimate relationships. Consistent with findings from other studies, the perceptions of individual men and of what they believe about their community, shows that men still support gender roles that define them as having the power and control in the domestic sphere.

Additionally, women are challenging these gender attitudes. This is likely to result in gender violence as men feel their gender roles are being undermined (Strebel, 2006). This shows that there is need for awareness training among men on gender sensitivity and equality. Educational campaigns against violence need to be widely spread.

Other factors found to trigger violence in the province included drug and alcohol abuse and childhood abuse. Consistent with findings in literature, childhood

[37] http://www.westerncape.gov.za/gc-news/405/9786

abuse is a risk factor of IPV and non-partner rape (Abrahams, 2006; Anderson, 2007; Jewkes, 2006). Our current study found that a greater proportion of men who experienced childhood abuse reported IPV perpetration and non-partner rape than men who were not abused in childhood. We noted high levels of physical abuse in all the four provinces. This underscores for the need to develop strict control measures, particularly in the area of corporal punishment, which is taking place illegally behind closed doors in homes and in schools. It is critical to prevent all forms of child abuse. There is a great need to promote healthy and happy family environments. This is very critical since these immediate social environments have a great bearing on the outcome of children in adulthood. Interventions need to be put in place to teach parents to bring up children in environments that are not harsh to children. For those children who have suffered child abuse, there is need for adequate psychological support systems to enable healing. Men need to be provided with alternative means of handling aggression and conflict (Abrahams, 2005). More diagnostic studies that seek to understand the root causes of violence should be undertaken in all communities as these provide crucial information in devising preventive measures.

As was seen in the political discourse analysis, for any national agenda to succeed there is greater need for political will and commitment. Politicians need to upscale their commitment by including GBV in most of their public addresses. The addresses should touch on all facets of GBV including causes, effects and prevention. Above all, the government needs to treat GBV as a national crisis and render the necessary financial support to curb the scourge.

CHAPTER 5
EFFECTS OF GBV



Survivors of GBV suffer from mental health and low self esteem. *Photo: Gender Links*

Key facts

- Over a quarter (28%) of women who were physically abused in the survey suffered injuries.
- Only 12 of the women (24%) who sustained injuries went to a health facility for treatment.
- Thirty of these injured women (59%) had serious injuries and were bedridden as a result of assault.
- Twenty-three of the injured women (45%) had to take days off work because of the injuries sustained.
- A significantly higher proportion of women who experienced physical IPV in their lifetime were diagnosed with an STI, compared to the proportion of women who had not experienced IPV.
- A higher proportion of women who experienced non-partner rape were diagnosed with STI compared to those who had never been raped.
- Thirteen percent of IPV survivors and 29% of rape survivors reported an HIV positive status.
- The most common mental health problem among women who had experienced intimate partner violence was depression.
- Forty-one percent of survivors of rape felt depressed compared to depression in just 24% of women who had never been raped.
- Twelve percent of survivors of non-partner rape had suicidal thoughts in the last month.
- Almost half the men (46%) believed that rape survivors may have been promiscuous.



"My name is Stephanie. When I was three months old, my mother left me with my grandmother who then sent me and my brother to a foster home. It was unpleasant there because no one really liked us. After five years, my aunt came to fetch us. We went to stay with her for four years and during that time her husband sexually abused me. When I tried to tell my aunt about it she wouldn't believe me. I was gang raped twice.

In 1996 we went back to live with my grandmother. She couldn't provide us with the things we wanted or needed so as a youngster I turned to prostitution so we could eat. It became a necessary task and my grandmother would even ask, 'Aren't you going to find food money?'

If there was nothing in the fridge I would tell her not to worry as I would make a plan. One day my cousin raped me. I cried and couldn't even bear looking at him after that day. At the age of 12 I left home and I met a man who promised to look after me, all I had to do was have sex with him. After he finished doing what he wanted, he threw me out like I was no good to him.

I lived on the streets for two years and had to sell my body to look after myself and to buy clothes and food. This is how my horrible life became a mess. I never knew my mother until I was 16 years old but there was no bond between the two of us. I don't know the feeling of a real mother's love. Being raped and beaten several times, and sexually molested and never being listened to makes it a bit worse. I was left with lifetime scars on my bum and eyes and this has made me lose trust in any man.

I know some of the guys who raped me. I was gang raped again recently and I am still dealing with it. It's hard but somehow I've overcome the worst but I still cry most nights when I just think of all the abuse. Today I know people will read my story and understand why I did what I did. I wasn't doing it because I loved to do it, but I was forced to do it."

Stephanie represents the women who have had it hard in life. From the young age of three months, she faced rejection from her family. During subsequent years, she suffered molestation and gang rape several times. Driven by poverty she resorted to prostitution so that she could look after her family. This story illustrates how witnessing or experiencing GBV in childhood can have negative outcomes in later years.

Previous research shows that GBV has negative mental, physical, economic and social effects on victims and their families (WHO, 2010; Kaur & Garg, 2008). It also has profound effect on the general development of the country (Suffla, 2004). The effects are both long term and short term. Intimate partner violence results in poor health outcomes that are comparable to, and in some cases exceed, poor health outcomes from other known health risk factors (WHO, 2010). The physical effects include injury while mental issues include depression, insomnia and fear. Social effects speak mainly to re-victimisation and stigmatisation, (Peltzer et al, 2013). The association between GBV and STI and HIV infection is well documented, with GBV increasing the likelihood of infection (Campbell and Lewandowski 1997). All these factors consequently affect victims' participation and performance in economic activities.

The economic dependence of victims on their perpetrators exacerbates recurring acts of violence. Another negative result of GBV is that it passes from one generation to the next. Young boys who witness IPV are at increased risk of also becoming perpetrators of domestic violence, while girls exposed to these patterns of abuse are more likely to be vulnerable to victimisation later in life.[38] (Anda et al., 2001; Dube et al., 2002). Thus, the negative consequences of violence against women lasts a lifetime and across generations with adverse consequences on the health and economic well-being of individuals, families, communities and societies. [39] This chapter reports on results from the responses of women participating in this study. Researchers asked the women questions that covered a range of indicators, including health contraceptive

[38] The co-victimisation of the mother and child in relationship to Domestic Violence, RAPCAn, MRC.
[39] World Health Organization/London School of Hygiene and Tropical Medicine. Preventing intimate partner and sexual violence against women: taking action and generating evidence. Geneva, World Health Organization, 2010.

use, condom use, HIV testing and results, sexually transmitted infections, and aspects of their mental health.

Pathways and health effects on IPV

Figure 5.1 overleaf shows the different ways that IPV can influence negative health outcomes and lead to death or disability. The main independent factor is experience of IPV, and the two major outcome variables are death and disability. Death can be homicide or suicide. The different pathways show how IPV can operate through intermediary factors resulting in the two outcomes. According to the chapter framework, IPV is directly linked to physical trauma, psychological trauma, and fear and control.[40]

Physical trauma

Physical trauma can cause injuries that may lead to death or disability. It may also influence substance abuse that, in turn, is associated with the occurrence of non-communicable diseases and consequent death or disability.

Psychological trauma

Psychological trauma can give rise to a wide array of mental health disorders such as post-traumatic stress disorder (PTSD), insomnia and depression. These can influence substance abuse or non-communicable diseases such as hypertension that may lead to death. Substance abuse in some cases is associated with somatoform disorders like irritable bowel syndrome and chronic pain with consequent death or disability. In other instances, psychological trauma may be directly associated with negative perinatal and maternal health outcomes such as low birth weight infants or miscarriage. These in turn can result in death.

Fear and Control

Like physical and psychological trauma, fear and control operate through intermediary determinants to cause death or disability in IPV victims. Fear and control may negatively influence health care seeking behaviour and sexual and reproductive health control because the victims lack autonomy. When one lacks autonomy, it is easy for them to be forced into unsafe sex, and difficult for them to seek care and other services. This can have negative effects like unwanted pregnancy, STIs, HIV, miscarriage or low birth weight infants. Such negative health outcomes may lead to death or disability.[41]

Physical injuries

This study found an association between the experiencing of episodes of GBV and immediate genital and bodily injuries. The survey asked women participants about the injuries they sustained as a result of physical abuse.

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

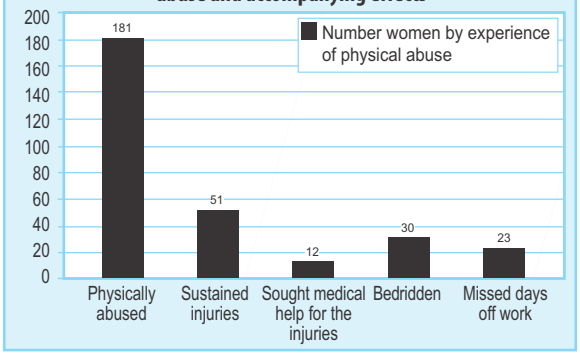
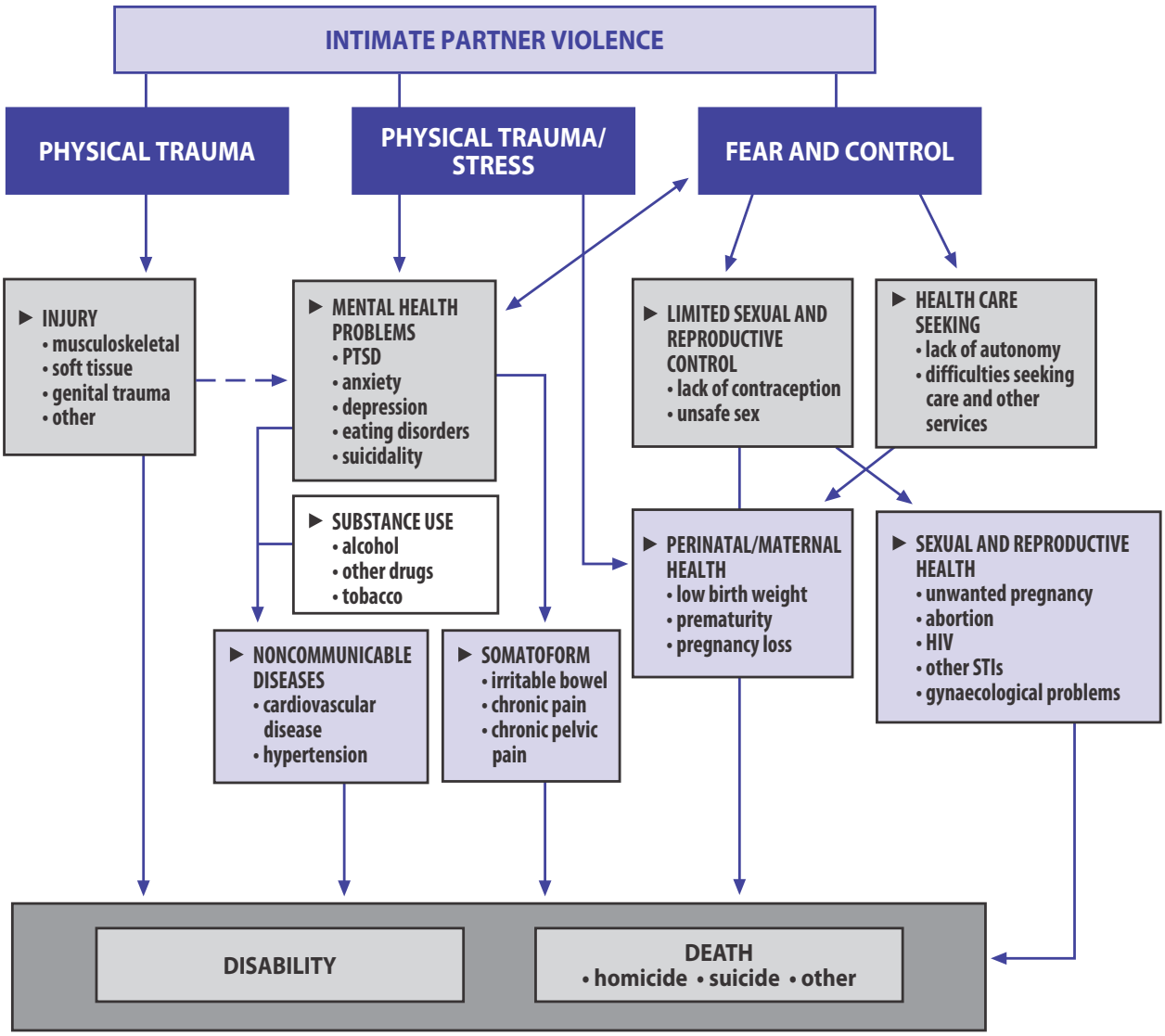


Figure 5.2 shows that 51 women in the survey (28%) who had suffered physical abuse also suffered injuries. Only 12 of the women (24%) who sustained injuries went to a health facility for treatment. Thirty of these injured women (59%) had serious injuries and were bedridden as a result of assault. Twenty-three of the injured women (45%) had to take days off work because of the injuries sustained. Being bedridden and taking days off work interferes with income generating activities and consequently the economic wellbeing of the victims.

[40] World Health Organization/London School of Hygiene and Tropical Medicine. Preventing intimate partner and sexual violence against women: taking action and generating evidence. Geneva, World Health Organization, 2010.
[41] World Health Organization/London School of Hygiene and Tropical Medicine. Preventing intimate partner and sexual violence against women: taking action and generating evidence. Geneva, World Health Organization, 2010.

Figure 5.2: Pathways and health effects on IPV



Source: WHO (2013) Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence.

Quite often, and in many settings, the health sector represents the first and only point of contact with the public sector for women, because most do not proceed to get legal assistance. According to the Consortium on Violence against Women, early identification, comprehensive management, documentation of the abuse and injuries sustained and appropriate referral may be the most effective strategies to prevent further injury and to stem the medical and psychological consequences of domestic violence.[42] As such, there is need to upscale education and training regarding IPV screening by health care providers.[43]

Sexual and reproductive health

Sexual violence had always been associated with high risk of contracting STIs (Meel, 2007). This study asked women whether they had ever had an ulcer on the vagina, a discoloured, smelly, itchy or uncomfortable discharge from the vagina, and whether a health worker had ever told them they had an STI. The findings are shown in Figure 5.3.

Figure 5.3: Prevalence of symptoms of and diagnosis of STIs

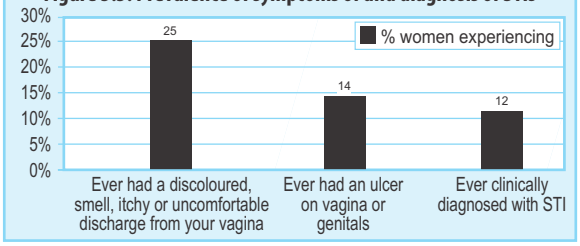


Figure 5.3 shows that 12% of the women interviewed had been diagnosed with STI at some point in their lifetime. A quarter of the women had experienced discoloured, smelly and itchy vaginal discharge. Fourteen percent had had a vaginal ulcer at some point in their lifetime. The statistics imply a high prevalence of STIs among women in the sample.

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 with an STI %	5.4	21	4.8	31.9	6.2	46.9	9.4	40.5
P value	0.000		0.000		0.000		0.002	

Table 5.1 shows a significantly higher proportion of the survivors of IPV were diagnosed with STI compared to the women who had not experienced the abuse (21% and 5% respectively). A significantly higher proportion of the women who experienced physical IPV in lifetime (32%) were diagnosed with STI compared to women who had not experienced IPV (5%). The proportion of women who experienced sexual IPV had significantly higher diagnoses of STI (47%) than the women who had never experienced sexual IPV (6%). Similarly, a higher proportion of women who experienced non-partner rape (41%) were diagnosed with STI compared to those who were never raped (9%).

[42] Martin, L& Jacobs, T. 2002. Screening for Domestic Violence: A Policy And Management Framework For The Health Sector. Consortium on Violence against Women

[43] http://www.scielosp.org/pdf/bwho/v86n8/18.pdf

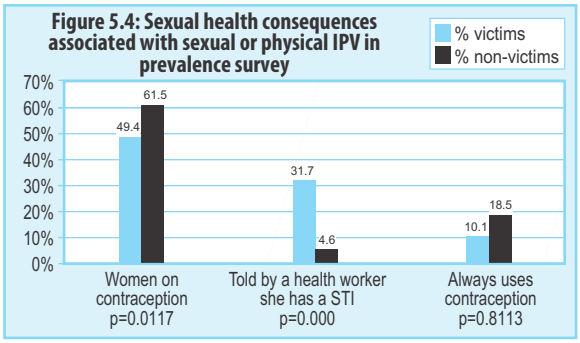


Figure 5.4 shows that there was a significant difference in the proportion of victims and non-victims that reported contraceptive use (62% and 49% respectively). A significantly higher proportion of survivors of sexual and physical abuse were diagnosed with STI compared to non-survivors (32% and 5% respectively). The survey also collected data on the prevalence of women reporting using a condom in the past year. There was no statistically significant difference in the use of condoms by victims and non-victims. It is usually expected that being physically or sexually abused may hinder the use of condoms. As is illustrated in the conceptual framework, IPV can instil fear in the victims which in turn can act as a barrier to condom or contraception use (WHO, 2013). It is evident that IPV can have negative impact on the all the demographic factors of women namely fertility, mortality and health.

HIV/AIDS

South Africa has the world's largest population of people living with HIV and AIDS. As of 2013, it was estimated that 5.26 million people in the country were living with HIV and AIDS (Press release, Statistics South Africa midyear report, 2013). A 2012 national household survey estimated 6.4 million people living with HIV and AIDS. The estimated prevalence of HIV (the proportion of people living with HIV in the country) increased from 10.6% in the 2008 HIV household survey, to 12.3% in 2012.[44]

The impact of gender violence on risk of HIV infection among South Africa women is well documented.[45,46] Previous research in different settings has shown a positive association between GBV and HIV. This study did not test for HIV but asked women whether they had tested for HIV and what result they obtained.



TAC WC and Free Gender marched against Rape, GBV and hate crimes in Khayelitsha.
Photo: http://www.districtblogs.co.za/free-gender-tac-marches-against-hate-crimes-rape-and-gender-based-violence-in-our-communities/

[44] http://www.hsrc.ac.za/en/media-briefs/hiv-aids-stis-and-tb/plenary-session-3-20-june-2013-hiv-aids-in-south-africa-at-last-the-glass-is-half-full#sthash.WWkM4H0b.dpuf
[45] 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.
[46] 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.

Table 5.2: HIV testing and results		
When did you last have an HIV test	**% women**	**% men**
Never tested	33.8	23.5
Last 12 months	33.9	9.5
2-5 years ago	26.1	22.6
More than 5 years ago	6.2	44.5
HIV Status		
Negative	91.3	96.8
Positive	8.7	3.2

Table 5.2 shows that the majority (66%) of the women interviewed in this study had tested for HIV and the majority of those that tested (34%) had done so in the 12 months before the survey. It is noteworthy that a third of the women said they had never tested for HIV. Of the women who collected their HIV test results, 9% reported an HIV positive status. This is evidence to the need to upscale HIV awareness programmes particularly in remote rural areas. A greater proportion of men than women had tested for HIV. Seventy-seven percent of the men compared to 66% of the women in the survey had tested for HIV. However, in the past 12 months, only 10% of the men had tested for HIV. The majority (45%) of men who had tested for HIV did so more than five years ago. This is a cause for concern because it is requisite for one to test regularly. The proportion of HIV positive men was lower than the proportion of women found to be HIV positive in the study. Nine percent of women compared to 3% of men were HIV positive. Consistent with results from other studies, women were disproportionately infected with HIV (McPhail et al, 2002). This indicates a need to continue focusing on preventing HIV infection among women of all ages.

Figure 5.5: HIV positive status among survivors and non-survivors

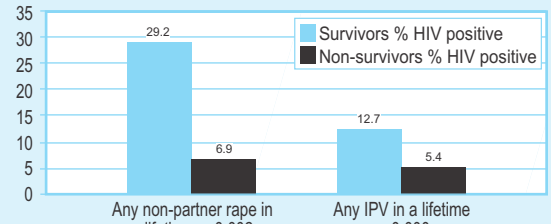


Figure 5.5 shows a significantly higher proportion (13%) of the IPV survivors reported an HIV positive status compared to non-survivors (5%). Similarly, a higher proportion (29%) of the survivors of non-partner rape were HIV positive compared to non-survivors (7%). Various studies in South Africa and worldwide have shown a significant association between rape and HIV infection (Meel, 2007). During rape, the risk of HIV transmission is amplified by physical trauma and non-use of condoms that protect from HIV infection.

Consistent with other studies on GBV, (Ellsberg & Betron, 2010), women who experienced violence were more likely to be HIV positive or have an STI. These findings confirm that GBV is interlinked with HIV and that concerted efforts should be taken to detect GBV early to prevent its progression and consequent HIV infection. According to the South African National Burden of Disease Study (2000), HIV/AIDS was the leading cause of premature mortality in the Western Cape. This once again points to the need to seriously consider GBV screening by health personnel to prevent continuing GBV and HIV infection.

Mental Health

Mental health is an important foundation for the attainment of emotional, intellectual, economic, social and educational well-being. Accordingly, mental disorders are an important contributor to the worldwide burden of disease (WHO, 2001). The conceptual framework at the start of this chapter shows that GBV can result in mental health disorders. South Africa put forward the Mental Health Care Act in 2002 (promulgated on 15 December 2004). The Act seeks to ensure that the care, treatment and rehabilitation of persons who are mentally ill conforms to the constitution and in particular, the right to equality and dignity, which are founding principles as well as rights enshrined in the constitution.[47] This study asked women about their experience of mental health disorders including suicidal thoughts and depression.

[44] http://www.justice.gov.za/legislation/acts/2002-017_mentalhealthcare.pdf

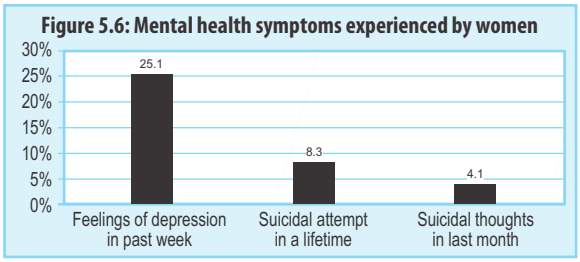


Figure 5.6 shows that a quarter of women participating in the study reported feeling depressed in the week before the survey. Eight percent of the women had attempted suicide in their lifetime and 4% experienced suicidal thoughts in the month before the survey. These findings demonstrate the high magnitude of the mental health burden to the society. The question therefore becomes, is the health system adequate to meet these needs?

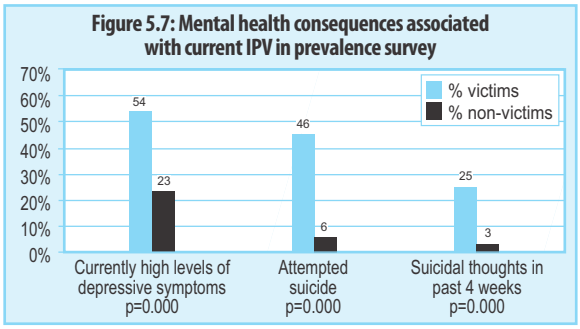


Figure 5.7 shows the proportion of women with current mental health problems among victims and non-victims of IPV. The most common mental health problem among women who had experienced intimate partner violence was depression. Fifty-four percent of survivors, compared to 23% of non-survivors, expressed high levels of depressive symptoms at the time of interview. Forty-six percent of the women who suffered abuse had attempted suicide. On the contrary, only 6% of non-IPV survivors had attempted suicide. A quarter of the survivors compared to 3% of non-IPV survivors experienced suicidal thoughts in the month prior to survey.

These findings demonstrate the effects of sexual violence on the victims' mental health. A study by Bach and Louw similarly found a significant correlation between experience of violence and depressive symptoms among Venda and Northern Sotho adolescents in South Africa (Bach & Louw, 2010). Mental health interferes with the women's agency and their ability to engage in economic activities or to leave violent relationships.[48] As was highlighted in the conceptual framework, mental health can lead to substance abuse. This calls for vigorous efforts to provide psycho-social support to victims of violence as well as to empower them to be survivors and victors.

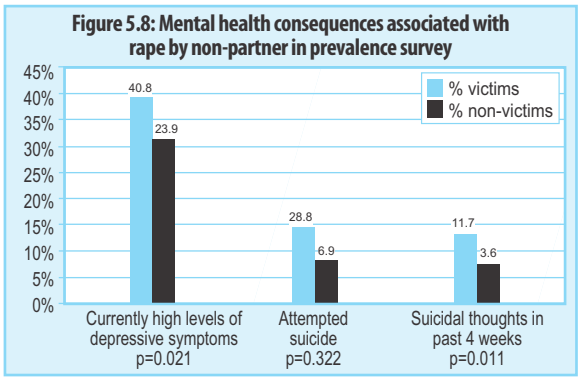


Figure 5.8 shows the prevalence of poor mental health symptoms among rape survivors and non-survivors. A significantly higher proportion of the women who were raped had very high levels of mental ill health compared to those among women who had not been raped. Over one third (41%) of women who had been raped expressed very high levels of depressive symptoms. A higher proportion of women who had been raped by a non-partner (29%) attempted suicide and, significantly, were more likely to have had suicidal thoughts in the previous week compared to women that had not experienced rape.

[48] http://www.aidstar-one.com/sites/default/files/AIDSTAR One_Gender_Based_Violence_and_HIV_tech_brief.pdf

Table 5.3: Mental health consequences associated with physical IPV and rape experience in 12 months before the survey		
	% non-survivors	% survivors
IPV experience		
Feeling depressed p=0.000	20.1	41.3
Suicidal attempt in lifetime p=0.000	4.5	20.1
Suicidal thoughts p=0.000	2	10.3
Rape experience		
Feeling depressed p=0.159	24.8	46.9
Suicidal Attempt in lifetime p=0.084	8.1	30.9
Suicidal thoughts p=0.332	4.1	11.7

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. More than a third (41%) of women who experienced physical IPV in the 12 months before the survey reported feeling depressed while a fifth (20%) of the women that did not experience physical IPV in a similar period had attempted suicide. Twenty percent of physical IPV survivors compared to 5% of non-survivors attempted suicide while 10% of the survivors and 2% of the non-survivors had suicidal thoughts. There was no statistically significant difference between survivors and non-survivors of rape in regards to attempting suicide, feeling depressed or having suicidal thoughts.

Participants from the "I" Stories shared their experiences, highlighting the same plight as the women in the survey. Six of the 18 women who experienced violence sustained injuries varying from swollen lips to fractured limbs. Other effects centred on the psycho-social factors affecting the victims. It was evident from the stories that violence brings about significant stress for victims. Some found themselves harbouring anger and hatred towards all men. Others were caught up in the traps of self-blame and self-pity. One woman lost her baby in pregnancy as a direct effect of violence. It was apparent from all the accounts that violence is a traumatic experience that may leave behind scars that will take a lifetime to heal.

Schlebusch (2012) postulates that on average, 10% of non-natural deaths in South Africa in young people are due to suicide. The rates translate into approximately one to two suicides, and 20 or more suicide attempts, per hour (Schlebusch, 2012). There are also estimates that by 2020 suicidal rates will increase to one death by suicide every 20 seconds, and one suicide attempt made every two seconds (Bertlote, 2002). Such findings call for urgent attention. There is need to develop appropriate therapeutic interventions as well as to upscale mental health services to prevent suicide.

Stigma and secondary victimisation

The social effects of rape on women include blame and condemnation in their communities. Apart from blame, there is stigma or labelling associated with having experienced rape. Women and men participating in the survey responded to questions on their personal and perceived community views about rape survivors.

Excerpt from Christel's story:
"There were times when I would think to kill myself and I would just think and cry, but then I think about my kids. They still need me because they are young and they love me very much. My children are everything to me."

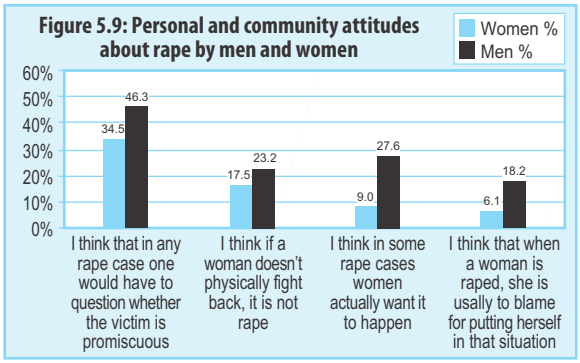


Figure 5.9 shows a greater proportion of men than women exhibited attitudes that blame and stigmatise rape survivors. Forty-six percent of the men believed rape survivors may have been promiscuous while 28% said in some cases women wanted it to happen and 23% said if women did not fight then it was not rape. Eighteen percent said survivors put themselves into compromising situations. Although in relatively lower proportions, the women affirmed these notions and agreed that women are to blame for rape, wanted it to happen or would not be raped if they fought back. Levels of stigmatisation of rape survivors were considerably high in this study, particularly among men. Negative attitudes and prejudices provide a breeding ground for the pandemic. Reducing the level of stigma attached to rape will encourage more women to open up about their experiences. This will enable survivors and the various available support systems to deal with the situation, thereby promoting good mental health. It is important to target communities, especially the men, in raising awareness against GBV and to reduce the level of stigmatisation of rape survivors.

Intergenerational effects

As shown earlier, GBV affects victims in many different ways. It also has negative effects on the children exposed to it. Exposure to IPV is distressing to children and is associated with a wide range of mental health outcomes both in childhood and in later years of life. Studies also show that children who are exposed to violence have a higher risk of becoming perpetrators if boys, and victims if girls, later in their lives.[49]

The 2008 National Youth Lifestyle Study by the Centre for Justice and Crime Prevention found that many young people are growing up witnessing violence and criminal activities in their communities, yet 74% of young people questioned in the study believed adults in their communities were setting a good example. In a 2009 study conducted by Professor Rachel Jewkes, head of the Women's Research Unit of South Africa's Medical Research Council, 62% of surveyed boys over the age of 11 years said they believed that forcing someone to have sex was not an act of violence.[50]



A family collects wood. *Photo: Judith Motsweu*

The escalating trend of sexual offences and violence among learners in South African schools testifies to this. The NPA and Department of Education are part of the campaign against sexual abuse and bullying spearheaded by the Proudly South African Campaign. This campaign is a much needed intervention that seeks to sensitise young learners so that they shun sexual engagement, bullying and violence in schools. Screening and counselling services should be readily available in schools for children who are exposed to violence.

[49] National Survey on Children's exposure to violence (2011); https://www.ncjrs.gov/pdffiles1/ojjdp/232272.pdf
[50] http://www.westerncape.gov.za/news/sexual-violence-everyones-concern

Costs to the economy

Apart from the social and health implications of GBV, it also has negative economic impacts on both the survivor and the nation as a whole. GBV has quantifiable economic costs although these are not a true reflection of the extent since many cases go unreported. However, for this study the DOJ&CD provided the costs it incurs in its response to GBV.

Table 5.4: Current running cost for the average Thuthuzela Care Centre

Cost	Per month	Per annum
Fax	R 3 500.00	R 42 000.00
Groceries	R 667.00	R 8 004.00
Clothing	R 2 500.00	R 30 000.00
3G	R 750.00	R 9 000.00
Telephone	R 2 500.00	R 30 000.00
Rentals	R 3 200.00	R 38 400.00
Cell phones	R 1 950.00	R 23 400.00
Travelling	R 15 000.00	R 180 000.00
Running cost total	***R 30 067.00***	***R 360 804.00***
Salaries site co-ordinator (219 504 per annum), victim assistant officers (177 798 and 604 998 per annum)	R 83 525.00	R 1 002 300.00
Total Costs	**R 113 592.00**	**R 1 363 104.00**

Table 5.4 shows the average total cost of running a Thuthuzela Care Centre (TCC) in South Africa. The total cost per month is R113 592, which amounts to more than R1.3 million per year. Given that currently there are 32 fully operational TCCs, this means that R43.6 million is being used towards the operation of TCCs nationwide per annum.[51] In the Western Cape there are four TCCs and only three are fully functional. Considering fully functional TCCs only, Western Cape is spending R4 089 312 towards the operation of TCCs.

Table 5.5: Human resources costs

DVA Personnel	Number	Unit salary	Total salary expenditure
Court clerks	35	R 115 212.00	R 4 032 420.00
SOA Personnel			
District magistrates	37	R 708 136.00	R 26 201 032.00
Dedicated regional magistrate	15	R 944 089.00	R 14 161 335.00
Intermediaries	164	R 170 799.00	R 28 011 036.00
Total		**R 1 938 236.00**	**R 72 405 823.00**

Source: Project on investigating expenditure relating to GBV: Questions to DOJ&CD.

Table 5.5 shows the costs incurred for hiring specialist personnel. A lot of money is being spent on responding to GBV. The major staff costs are those for intermediaries.

[51] KZN GBV Baseline Study, 2013.

Table 5.6: Infrastructural victim support services for sexual offences 31 March 2013				
Infrastructural support services	**Standard assets**	**Asset costs per room**	**Total number of court rooms**	**Expenditure**
Courtroom	Closed circuit TV system (incl. monitor, camera, microphones, etc.)	34 841	298	R 10 382 618
Testifying room	Couch, three chairs, small table, blinds (to block sunlight from camera), air conditioner, automatic dolls	7 700	349	R 2 687 300
Private Children's waiting room	Seating for children, small table, couch/small bed, toys, information screen	17 200	88	R 1 513 600
Adult waiting room	Seating for adults, small table, information screen	12 300	116	R 1 426 800
Total				**R 16 012 318**

Source: Project on investigating expenditure relating to GBV: Questions to DOJ&CD.

With regard to the establishment of the required infrastructure to support victims of sexual offences, a total of R16 million was spent.

The total spent on running TCCs, salaries for specialist staff and infrastructural services amounts to R132 035 469 (USD13 164 715).[52] Based on South Africa's 2012 Gross Domestic Product (GDP) which was worth 384,31 billion US dollars, the value of responding to GBV by the DOJ&CD amounted to 0.03 percent of the GDP. It should be noted that the costs mentioned here are the ones incurred by the DOJ&CD only. Costs incurred by other departments such as the Department of Health and SAPS have not been established in this study. Equally important are the costs borne by the survivors and their families which more often than not compete with the vital expenditure needs of food and education. From this, it is evident that GBV impedes economic development at personal, family, community and macro levels and thus should be responded to with urgency.[53]

Costs incurred by the Department of Social Development responding to GBV

The Department of Social Development (DSD) makes transfer payments to non-profit organisations that deliver services on behalf of the department. The services are in line with the core programmes of the department, legislatively mandated and/or specialised in nature. The DSD enters into a transfer payment agreement with all funded entities specifying the service delivery conditions, funding arrangements and conditions as well as agreed outputs and outcomes.

The Victim Empowerment Programme received a total amount of R11.9 million. This went towards assisting victims of crime and the administration of restorative justice. Crime prevention and support units received around R6 million.

Conclusion

This chapter has shown GBV has a wide array of negative effects on victims that include physical injuries, poor mental health, increased risk of HIV and STIs. Based on the findings, the health sector has a great role to play in the elimination violence against women. According to the WHO's new clinical and policy guidelines on the health sector response to VAW there is need to integrate issues related to violence into clinical training.[54] Injured persons should be screened for early detection of violence. Similar

[52] Add the total costs presented in each of the tables above
[53] KZN GBV Baseline Study, 2013.
[54] http://www.prb.org/igwg_media/crucial-role-hlth-srvices.pdf

procedures can be applied to women who access reproductive health services.

Women in the study exhibited high levels of mental health symptoms. In South Africa, as in the rest of the world, mental health services have not been given due attention and resources. Thus, women might end up resorting to substance abuse. This could explain the high levels of alcohol consumption among women in the Western Cape. Mental health problems resulting from GBV have far-reaching effects compared to the physical effects.

The chapter also showed that GBV has negative financial implications. The costs borne by the survivor, community and nation in the process of responding to GBV could be channelled towards other developmental issues. Here, it was difficult to ascertain the actual costs incurred by the South African government in responding to GBV. This was due to bureaucratic and data management issues. In order to give a holistic picture of all the negative effects of GBV there is need to document all costs incurred by different stakeholders in responding to as well as preventing GBV. Therefore, this study recommends that government personnel be capacitated in data management so that data is readily available.

Overall, the findings from this chapter shed light on the negative effects of GBV, underscoring the need for all relevant stakeholders to join hands as they work towards the total elimination of GBV in the Western Cape and South Africa as whole. Efforts to curb GBV must bring on board all the relevant stakeholders including the media, health services, policy makers and social services. More lives would be saved if GBV was prevented.

CHAPTER 6
RESPONSE



Daniel and Carol Prins, Mossel Bay Municipality - Changing Lives in South Africa.
Photo: Ntombenthsa Mbadlanyana

Key facts

- Rape accounted for almost three-quarters of all reported sexual offences (73%) recorded nationally.
- The National Department of Health has put in place policies like the Primary Health Care Package and National Management Guidelines for Sexual Assault Care, to guide treatment and care of victims of sexual assault and domestic violence.
- The Department of Justice and Constitutional Development provides court services and ensures access to justice.
- The South African Police Service provides 150 Victim Friendly Rooms (VFRs) in Western Cape Province. These rooms offer a confidential and comfortable atmosphere where survivors are educated about their rights and available options to respond to their situation.
- There are 25 Family Violence, Child Protection and Sexual Offences units in the Western Cape.



"My name is Christal and I'm 24 years old. I have three sons and their father's name is Brian. We've been in a relationship for seven and a half years. The abuse started in December 2010 when he started using drugs like tik, mandrax, dagga and alcohol. I was pregnant at the time and he started to slap me and force me to have sex with him. If I refused, he would tell me it's because I had already slept with another man. In the middle of the night he would wake me from my sleep and tell me that I don't look like I've been sleeping. Then he would look on the floor for footprints and tell me that another man had been in the house. He would then take his fingers to feel my vagina to check that I didn't have sex with another man. Because he locked the doors, I couldn't go outside the house during the day and couldn't speak to other people. If I spoke to other people he'd say I was gossiping about him. Whenever my mother phoned the police, he would be gone by the time they arrived. I've run away almost ten times, but whenever I go to my family or friends he always finds me. Maybe someone tells him where I am. Whenever he found me at someone's house, he would beat me and say I ran away because I wanted to have sex with other women's husbands.

When he was at home he would take drugs and sleep day and night, and then tell me he was sorry, that he didn't mean to hurt me and that he loved me. One morning when a man, apparently a colleague of his, came to our house to fetch him to go to work, he refused to go. I asked him why he didn't want to go to work and he said he didn't want to work anymore because he had three children and had already worked enough. I remember one day he was fighting with me in the middle of the street while I was pregnant. I had my second child in my arm and he threw me to the ground and kicked my head - that's how I got these scars on the left side of my face. When my parents defended me, he said they were defending me because they had a better man for me.

Brian became like an evil monster to me. At times I would run away but would have nowhere to go, and would sleep in the streets with my children. At the police station they told me I could not make a case because they had to catch him first. Only then could I open a case against him. I had to go back to him several times because I didn't have anywhere else to go. Whenever I went to my family there was financial problems because I have three kids. There were times I would think of killing myself and I just cried, but then I thought about my kids. They still need me because they are young and they love me very much. My children are everything to me.

Sometimes I would just sit in the house and wait for him to come and beat me because I was so used to the physical and emotional abuse. He would have sex with me in the morning or afternoon and I couldn't say no because of fear of more abuse. I wasn't feeling well during my pregnancy because of stress and abuse. Sometimes he fought with me in front of my kids and didn't even care. He even says that our children are not his because they do not have his surname and we're not married. He would tell me to leave, but before I even reached the door he would beat me and tell me that I had another man and that's why I wanted to leave. I have never cheated on him once, but he always wanted to punish me for being unfaithful. He even told me one day that I would never have another man for as long as he was around. If he ever found out I have another man he would kill me, then the man.

Every time I went back to him he would tell me that he was finished with drugs and wanted a chance to live his life with me and the kids. He would be fine for a few weeks and then do drugs behind my back and we'd be back to square one. I have been deeply hurt so many times by him. I gave him so many chances to prove himself but I just ended up heartbroken. I have made my choice now because I want to live a better life for the sake of my children who deserve better. I am not going back ever again. I am leaving the past behind and moving on. For as long as I stay away from my kids' father I know I can do this on my own."

This is a story of a hopeless woman who seemed trapped in an abusive relationship. She yearned for her freedom and attempted to leave her husband several times but always found herself back with him.

Due to financial constraints her family could not help her much as she has three children. She sought the help of the police but to no avail. This left her in despair and feeling hopeless, just like several women out there who are victims of GBV. Eventually she gathered the courage to leave this relationship. She is in a better space and is determined to move on.

This chapter explores the various legal provisions and response systems that have been put in place to promote gender equality and protect women's rights.

Ratification to international and regional instruments

Political commitment is pivotal in efforts to end GBV in any country, and this can be assessed by the ratification and adoption of legal instruments and the existence of institutional mechanisms which facilitate the elimination of GBV. Adherence to international conventions and resolutions on human rights both symbolise and enable government commitment to preventing violence (UN-GA, 2006).

South Africa is partisan to conventions to combat gender based violence, through membership and collaboration in various bodies that are opposed to gender based violence including the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the Beijing Platform for Action (BPA), the Protocol to the African Charter on Human and Peoples Rights on the Rights of Women in Africa, and the Southern African Development Community (SADC) Protocol on Gender and Development.

The 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 CEDAW in 1995.

SADC Protocol on Gender and Development

The Heads of State of the SADC including South Africa signed a declaration committing their countries to embedding gender firmly in the agenda of their Programme of Action, and to repeal and reform all laws and social practices which subject women to discrimination. The declaration further commits to protect and promote the human rights of women and to 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.

UN 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 for their dignity. Victims are entitled to access all mechanisms of justice and to prompt redress for the harm and loss suffered. They are also entitled to receive adequate specialized assistance in dealing with emotional trauma and other problems caused by the impact of victimisation.

Legal framework

Ideally, ratification of regional and international frameworks should inform effective legal instruments to end violence against women at country level. This demonstrates the country's commitment to upholding human rights. In South Africa, the government has put in place laws that seek to address GBV in public and private life.[55] Informed by the above outlined international and regional conventions, the South African government has adapted legislative frameworks accordingly as follows:

- Domestic Violence Act (Act No 99 of 1998), implemented on 1 November 1999. A draft Bill to propose amendments to the Domestic Violence Act was finalised by June 2012, co-ordinated by the Dock;
- Criminal Law Amendment (Sexual Offences and Related Matters) Act, 2007 (Act No 32 of 2007), implemented in phases from December 2007;
- The Protection from Harassment Act, 2011 (Act No 17 of 2011), implemented by March 2012;
- The Children's Act, 2005 (Act No 38 of 2005), implemented on 1 April 2010;

[55] www.justice.gov.za/VC/docs/international/2006_Draft%20UN%20Convention%20Victims.pdf

- The Child Justice Act, 2008 (Act No 75 of 2008), implemented on 1 April 2010;
- The Older Persons Act, 2006, implemented on the 1 April 2010;
- The Prevention and Combating of Trafficking in Persons Bill, currently being deliberated upon by the Portfolio Committee on Justice and Constitutional Development; and
- The Protection from Sexual Harassment Act 17 of 2011.

Domestic Violence Act

The Domestic Violence Act (DVA) of 1998 targets violence in the home. Such violence exists in a wide range of domestic relationships including between individuals who are or were 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 household poses a challenge when analysing South African Police Services (SAPS) and court data to extract the true extent of GBV. One of the immediate and positive outcomes of this study has been the commitment by SAPS to include a relationship category in the crime registration database.

Sexual Offences Act

In compliance with Constitutional provisions, CEDAW and BPA obligations, South Africa introduced the Sexual Offences and Related Matters Amendment Act (SOA) (Act No 32 of 2007), which makes it an offence to have sexual intercourse with a girl under the age of 16. The SOA received approval from stakeholders. 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.

Protection from Sexual Harassment Act of 2011

The law came into operation on 27 April 2013. The purpose of this act is to provide for the issuing of protection orders against harassment and to afford victims of harassment with an effective remedy against such behaviour.

Public awareness of national legislation

Participants in the prevalence and attitudes survey were asked whether they knew about the DVA and SOA as response mechanism to gender violence.

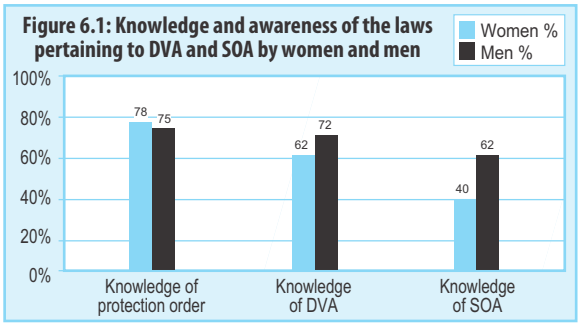


Figure 6.1 shows the responses by men and women in regards to their awareness of the existing laws that address DVA and SOA. Men are more knowledgeable about the laws that protect women against violence. More than three quarters of women (78%) and men (75%) knew about the protection order. More men than women knew about the DVA and the SOA. The SOA is the least known law among women and men, with only 40% of men and 62% of women aware of it. It is evident that there is need to raise more awareness on the laws that address GBV, particularly amongst women. It is also important to set up interventions which prompt men to translate knowledge into behaviour at an individual level. Early primary interventions which shape the attitudes, knowledge and behaviour of males in childhood are crucial in ensuring lifelong behaviours which do not promote gender violence.

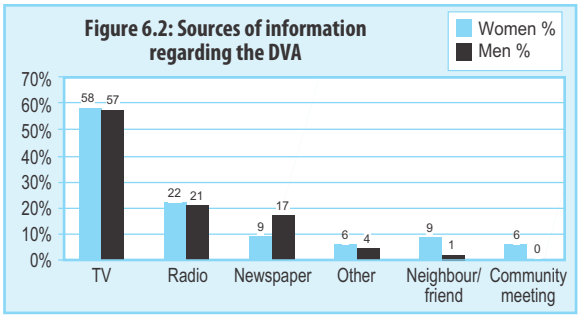


Figure 6.2 shows that the most popular source of information about the DVA is television. Over half of women (58%) and men (57%) heard about the DVA through this medium. Information disseminated by radio about the DVA reached far fewer women (20%) and men (21%), while more men (17%) compared to women (9%) heard about the DVA by reading the newspaper. A greater proportion of women (12%) compared to men (5%) heard about the DVA through neighbours or community meetings. These findings are evidence of the need for greater outreach efforts in creating awareness around GBV laws.

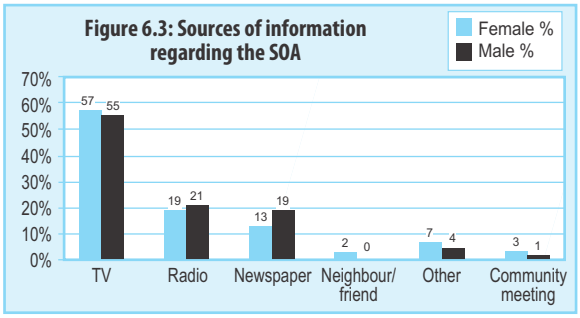


Figure 6.3 shows that the majority of women (57%) and men (55%) heard about the SOA through television. Again, information disseminated by radio about the SOA reached far fewer women (19%) and men (21%), followed by newspapers, with only 19% of men and 13% of women learning about SOA through this medium. Five percent of men compared to12% of women heard about the SOA through a friend or neighbour, community meetings and other means.

These findings show that the main sources of information for both women and men are TV and radio and hence campaigners should focus on these mediums. At the same time, there is need to accelerate efforts to disseminate information through other modes, e.g. community mobilisation and through the print media.

Evaluation of the DVA and SOA implementation[56]

With the SAPS and the Department of Justice & Constitutional Development (DOJ&CD) being the chief custodians of both the DVA and SOA, gaps have been identified in the implementation of these acts. Cutting across the board is the issue of inadequate resourcing allocated towards the implementation of the acts.

According to the research undertaken by the Tshwaranang Legal Advocacy Centre (TLAC), several police stations do not have the required resources to carry out procedures stipulated by the Acts. Also evident is ignorance of the fundamental issues pertaining to the Acts by key role players such as the police. One loophole in the DVA is the ambiguity as far as delegating responsibilities is concerned. The DVA places responsibilities on only one department, the SAPS, yet it places no corresponding legal obligation on other relevant stakeholders such as the Department of Social Development (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 need for legislative enforcement for implementation to be effective (TLAC 2010).

Policies for Service provision

Learning from other countries worldwide, South Africa has put in place significant victim centred policies. This kind of approach focuses on co-ordinated efforts to deal with survivors of violence. It brings different sectors together; the police, medical officers, social

[56] Source: www.justice.gov.za/VC/docs/international/2006_Draft%20UN%20Convention%20Victims.pdf

services and the criminal justice system. As such, the respective sectors have their own departmental policies that provide for necessary services to the victims of violence. Some of these policies are outlined below.

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

In 2004, Cabinet approved a Service Charter for Victims of Crime in South Africa as well as Minimum Standards on Services for Victims of Crime, which was 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. They are intended to promote excellence in service delivery, thus promoting client satisfaction with the services delivered.[57]

National Policy Guidelines for Victim Empowerment

The National Policy Guidelines provide the regulatory framework for promoting and upholding the rights of the victims of crime and violence in order to prevent revictimisation within the criminal justice and associated systems. In addition, they provide 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.[58]

The Integrated Strategic Framework for the Prevention of Injury and Violence

The DSD developed this framework as a response to violence in November 2011. 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. This framework was developed through a multi-sectoral approach that included other national departments, provincial departments of health, civil society organisations as well as academic and research institutions including the Medical Research Council. The framework has resulted in the increase of the technological and professional staff capacity of the forensic laboratories to support the justice system. [59]

Health Sector



Western Cape TAC campaign for better health systems.
Photo: Treatment Action Campaign

Public health approaches to addressing GBV have been shown to be important in responding to GBV. However, it evident that some health care providers fail to diagnose and document GBV for various reasons including lack of time, poor clinical practices, traditional barriers and limited resources.[60] As such, the National Department of Health (NDOH) has put in place a policy to guide treatment and care of victims of sexual assault and domestic violence. The main health policy related documents are the Primary Health Care Package and National Management Guidelines for Sexual Assault Care.

The Primary Health Care Package for South Africa - a set of norms and standards for victims of sexual abuse, domestic violence, and gender violence

According to the policy, the service to victims of abuse requires co-operation between the health sector, the police and the DOJ&CD, provides counselling and referral of victims, STD prophylaxis and HIV testing, emergency contraception, care of injuries, medico-legal advice and documentation of evidence. Among the norms and standards for service are:

[57] Reported in the KZN GBV Baseline Study, 2013
[58] Source: http://www.npa.gov.za/files/Victims%20charter.pdf
[59] Source: http://www.npa.gov.za/files/Victims%20charter.pdf
[60] http://www.doh.gov.za/docs/reports/annual/2012/Health_Annual_Report_2011-12.pdf

- Every clinic should establish working relationships with the nearest police officer and social welfare officer by receiving visits from them at least twice a year.
- A member of staff of every clinic should receive training in the identification and management of sexual, domestic and gender related violence. The training includes gender sensitivity and counselling.
- A clinic should have a list of names, addresses and telephone numbers of the nearest accredited health care practitioners, police and social workers who would be involved in dealing with these cases.
- A clinic should have a list of names and addresses of non-government organisations (NGOs) or other organisations, e.g. community-based organi-sations which undertake appropriate counselling, Families South Africa (FAMSA), and AIDS Training and Information Centre (ATIC), for violence, child abuse and sexual offences.
- A clinic should have a room available at short notice for private, confidential consultations.
- A clinic should have adequate stock of emergency contraceptive pills.
- The clinic staff should fast track in a confidential manner any rape victim to a private room for appropriate counselling and examination.
- The staff should always include a question on gender violence in the history-taking from women with depression, headaches, stomach pains or a known abusive partner.
- The staff should include diplomatic probing of the domestic situation in taking histories of children with failure to thrive, recurrent episodes of trauma or behavioural problems.
- All cases of sexually transmitted disease in children should be managed as cases of sexual offence or abuse.
- When a person presenting at a clinic alleges to have been raped or sexually assaulted, the allega-tion should be assumed to be true and the victim should be made to feel confident that they are believed and should be treated correctly and with dignity. A detailed medical history should be recorded on the patient record card and a brief verbal history of the alleged incident should be taken and noted - with an indication that these notes are not a full account. The notes should be kept for three years.
- Staff should explain that referral is necessary to an accredited health practitioner and arrangements should be made expeditiously and while awaiting referral, emergency medical treatment should be given with the consent of the victim: prophylactic treatment against STD and post-coital contraception.
- The victim should be given information on the follow-up service and the possibilities of HIV infection, as well as what to discuss with the accredited health practitioner at the hospital or health centre.
- Victims should not wash before being seen by an accredited health practitioner.
- Women who have been raped or abused should be attended to by a female health worker and if this is not possible (e.g. a male district surgeon is on duty at the clinic), then another women should be present during the examination.
- The victim should be given brief information about the legal process and the right to lay a charge.
- If the victim indicates a desire to lay charges, the police should be called to the clinic.

Adapted from The Primary Health Care Package for South Africa

The Health sector is crucial in dealing with GBV in Western Cape Province. There is great need for continued monitoring and evaluation of the health sector in the province to ensure an effective and efficient response system.

National Management Guidelines for Sexual Assault Care

Women who have been raped have particular health needs which include psychological support, pregnancy prevention, protection against or treatment

for HIV and other sexually transmitted infections, and the management and documentation of injuries.[61] The National Management Guidelines for Sexual Assault Care ("National Guidelines"), developed by the DoH in 2004, are a notable achievement in the health care sector in responding to GBV. The National Guidelines include both general health standards for sexual assault management as well as specific standards relating to medical-legal examination and documentation, psychological support, reproductive health, and HIV. HIV related standards include voluntary testing and counselling, provision of post exposure prophylaxis (PEP), follow-up HIV testing, pregnancy prevention including emergency contraception, and referral of HIV-positive patients for further HIV management as shown in the following excerpt from the SOA.[62] These are currently being revised. They have been supported by a national policy and the development of a national curriculum for training health professionals in post-rape care.

Public services

At national level, individual responses of police or health personnel can exacerbate or ameliorate the negative impact of GBV. In South Africa, there has been some progress at departmental level and among Civil Society Organisations (CSOs) in providing services to survivors of GBV. Most government departments are oriented towards response and support while the thrust of CSOs is support and prevention campaigns. Whenever GBV survivors access these services, client data is collected as a routine exercise. For this chapter, data on access to services was obtained 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 organisation websites.

South African Police Services (SAPS)

The SAPS is mandated by the following legislature to respond to GBV:

Legislature	Year
Constitution of the Republic as the Supreme Law Act 108	1996
South African Police Act 57	2008
Domestic Violence Act 116	1998
National Instructions 7	1999
Sexual Offence Act 32	2007
Child Justice Act 75 of 2008	2008

According to the DVA, every member of the SAPS is obliged 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 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.

Specialised units within SAPS

In order to better respond to GBV, the SAPS has created specialised units whose sole responsibility is to address issues of domestic violence at police station level. To ensure that statements regarding GBV are taken behind closed doors and in privacy, 900 Victim Friendly Rooms have been created. Currently, the SAPS has 1124 police stations, not including satellite police stations and contact points where cases can also be reported. Police officers are being trained to deal with such cases. The training includes the five day Domestic Violence Learning programme.[63]

The Child Protection Unit

The Child Protection Unit (CPU) was established to prevent and combat crimes against children. It provides a sensitive service to the child victim in cases of rape, incest, the sexual exploitation among many others. Government has demonstrated leadership in ensuring that the Constitution, legislation, policies and international instruments are in place to provide statutory protection of children. The Children's Act

[61] http://siteresources.worldbank.org/INTPHAAG/Resources/AAGGBVHealth.pdf
[62] N J Christofides, D Muirhead, R K Jewkes, L Penn-Kekana, and D N Conco.2006. Women's experiences of and preferences for services after rape in South Africa: interview study BMJ. 2006 January 28; 332(7535): 209-213
[63] Republic of South Africa National Sexual Offences Act.

of 2005 sets out the principles relating to the care and protection of children, and defines the 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.[64]

Over recent years, the need has been identified for the expansion of the sensitive services for children and adult victims of family violence and sexual offences. This led to the establishment of the Family Violence, Child Protection and Sexual Offences Unit (FCS). The 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.

Family violence, child protection and sexual offences

FCS units have been re-introduced in all 176 SAPS clusters across the nine provinces. There are currently 2 155 detectives placed at these units, issued with 1 276 vehicles. Previously, the FCS units consisted of only 1 864 detectives.[65]



Figure 6.4: National distribution of FCS units

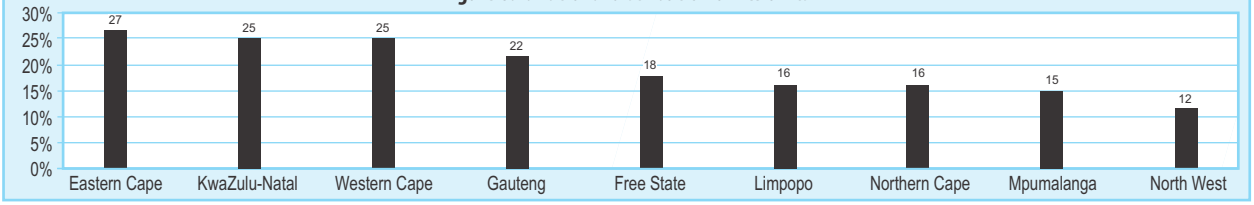
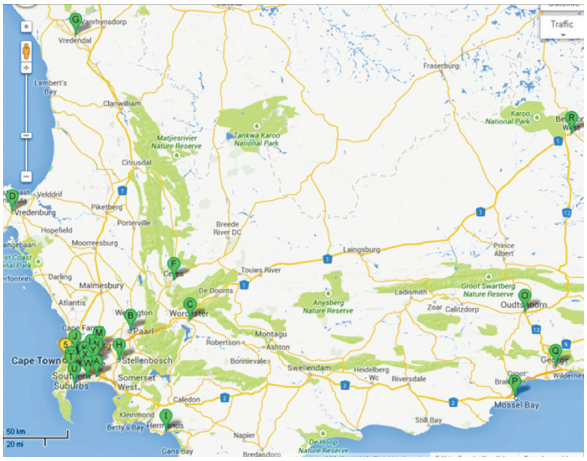


Figure 6.4 shows the distribution of the 176 units across the nine province of South Africa.The Eastern Cape has the highest number of FCS units in the country (27) whereas North West has the least. KwaZulu-Natal and the Western Cape have 25 units each. Gauteng Province has 22 units while the Free State has 18 units. Considering the high prevalence of GBV in the Western Cape presented in the study, there is a need for continual training of specialists to ensure adequate manpower in dealing with GBV issues. The primary goal of the FCS unit 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 CPU/FCS units. Awareness is fostered by multi-disciplinary meetings, articles in the media and the presentation of lectures and talks at schools, universities and church organisations. The lectures are presented to people of all ages, ranging from children to adults.

[64] http://www.pmg.org.za/print/report/20120215-department-justice-constitutional-development-implementation-domestic
[65] Source: http://www.saps.gov.za/org_profiles/core_function_components/fcs/establish.htm

Table 6.1: FCS units in Western Cape Province			
Cluster	**Location of unit**	**Personnel**	
Khayelitsha	Bellville	29	A
Paarl	Paarl	14	B
Worcester	Worcester	12	C
Vredenburg	Saldanha	7	D
Caledon	Caledon	6	E
Ceres	Ceres	4	F
Vredendal	Vredendal	7	G
Stellenbosch	Stellenbosch	10	H
Hermanus	Hermanus	6	I
Milnerton	Goodwood	9	J
Bishop Lavis	Goodwood	9	K
Bellville	Goodwood	8	L
Kraaifontein	Kraaifontein	10	M
Kuilsrevier	Bellville	10	N
Oudtshoorn	Oudtshoorn	18	O
Da Gamaskop	Mossel Bay	14	P
George	Heatherlands	18	Q
Beaufort West	Beaufort West	8	R
Cape Town Central	Cape Town	9	S
Wynberg	Wynberg	8	T
Muizenberg	Wynberg	4	U
Claremont	Wynberg	4	V
Mitchells Plein	Mitchells Plein	16	W
Nyanga	Mitchells Plein	22	X
Delft	Bellville	7	Y

As can be seen in this map, FCS units are concentrated in Cape Town. This is justifiable as more than 60% of the WC population resides in Cape Town. Frank et al (2009) conducted an assessment of FCS service provision in the country, with the specific objective of assessing the impact of the restructuring process of 2006. They found that the restructuring had done little by way of improving services to the victims of violence. The new structure was unable to offer continued specialisation of officers nationally, dedicated resourcing or specialised management and oversight of FCS cases.



One of the many gaps identified was that the restructuring resulted in the placement of FCS staff in service-delivery positions who: (1) were not 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, (5) did not have some of the basic requirements to undertake the job, e.g. driver's licenses.[66]

Victim Friendly Rooms

The SAPS has Victim Friendly Rooms (VFRs) at various locations where survivors of GBV are afforded a private and comfortable environment where they are informed about their rights and available options relating to their situation.[67] The atmosphere of confidentiality and privacy in the rooms seeks to enable survivors to make statements with ease. The police officers found at VFRs are especially trained to carry out their investigations with sensitivity.[68] In November 2013, Minister of Police, Nathi Mthethwa stated that there were 819 rooms established across

[66] http://www.rapcan.org.za/File_uploads/Resources/FCS_report_text_web1.pdf
[67] Select Committee on women, children and people with disabilities.
[68] Shukumisa Report 2011/2012. Monitoring the implementation of sexual offences legislation & policies: findings of the monitoring conducted in 2011/2012.

the country at police stations and 87 at other service points such as airports, railway police stations and coaches as well as at various satellite police stations. Ministerial spokesperson Zweli Mnisi further highlighted that the Western Cape has the highest number of such facilities at a police station level with 150 rooms, followed by Gauteng with 137 and KwaZulu-Natal with 135. Mnisi explained that Western Cape had the most number of facilities due to the fact that there are a huge number of contributing factors to violence against women and children in the province. The most significant is drugs, alcohol and gang violence.[69]

It is also important that the VFRs have the services of a trauma centre where the physiological needs of the survivors are addressed while statements are taken. Some survivors withdraw cases against perpetrators especially if an intimate partner is involved. Since it is the role of VFRs to provide the survivor with information on the options available, VFRs should adequately empower and offer support to survivors so as to minimise the chance of charges being dropped.



VICTIMS of crime will have more than just a shoulder to cry on at the newly launched Victim Friendly Facility at the Cape Town Central Police Station. *Photo: People Spot*

Forensics Unit

Specialist services like those offered by forensic social workers provide specialised technical analysis and support to investigators regarding evidence on gender-based violence related cases. According to the Deputy Minister of Police, Maggie Sotyu, imprisonments totalling 36 225 years, including 695 life imprisonments were imposed on perpetrators during the 2011/2012 period thanks to evidence provided by the Forensic Science Laboratory.[70]

The role of the Independent Complaints Directorate in the implementation of the DVA by SAPS

Since its inception, the Independent Complaints Directorate (ICD) has been responsible for monitoring the SAPS in 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.

Various types of non-compliance cases include, but are not limited to: failure to arrest the alleged transgressor; failure to open a docket and refer the matter for prosecution; failure to advise complainants of their 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, since the IPID Act 1 of 2011 came into effect on 1 April 2012, the IPID no longer has any mandate to deal with any domestic violence related non-compliance matters. Instead, the duty was conferred on the Secretariat for Police.[71]

Over the years, the ICD continually experienced challenges in terms of implementation of the DVA. According to their last report to the Parliament, the major challenge experienced by the SAPS was 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

[69] http://www.vocfm.co.za/index.php/voc/general/item/11251-victim-friendly-rooms-at-saps
[70] http://www.info.gov.za/speech/DynamicAction?pageid=461&tid=99977
[71] http://www.ipid.gov.za/documents/report_released/dva_reports/2010-2011/ICD%20-%20DVA%20%20July%202011%20-%20March%202012.pdf

provinces for the period July 2011 to March 2012. Western Cape recorded the highest (28) non-compliance cases. Of the 28 complaints of non-compliance received by the province, no application for exemption was received from the SAPS for cases in the period under review.

Police audits

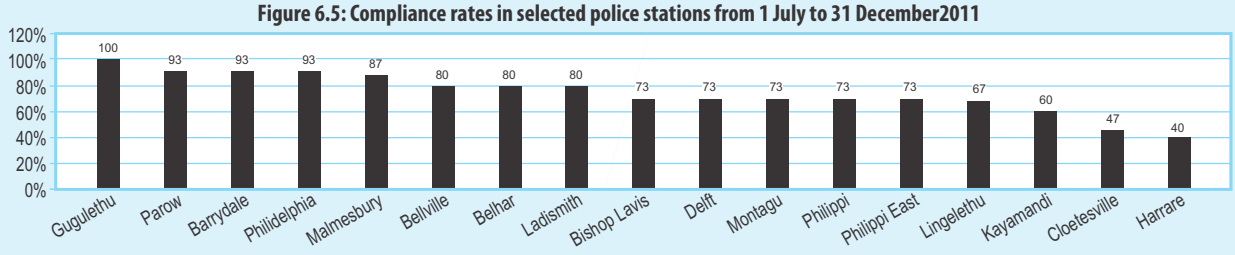
According to the SAPS National Instructions 3/2008, a police station is supposed to have a set of nine documents that provide a guideline of service provision to ensure that the police offer comprehensive services.[72] The nine documents are as follows:

- Sexual Offences Act 32 of 2007;
- Application by victim or interested person for HIV testing of the alleged offender;
- Notice of services available to victim;
- Notice containing information on confidentiality and how to deal with HIV test results;
- Copy of the SAPS National Instructions;
- Copy of the station orders;
- List of organisations providing services to rape survivors;
- Information about hospitals providing post exposure prophylaxis (PEP) to rape survivors.

The Western Cape ICD Provincial office conducted audits at 25 police stations to determine the level of compliance with the DVA and the SAPS National Instructions. Part of the audit included:

- An inspection of the SAPS domestic violence registers (508a and 508b);
- Ensuring the Community Service Centre had copies of the DVA;
- Ensuring that a list of service providers was available in the event that a victim of domestic violence needed service;
- Inspections of victim-friendly facilities to ensure the facilities were equipped to deal with domestic violence cases.

Figure 6.5: Compliance rates in selected police stations from 1 July to 31 December2011



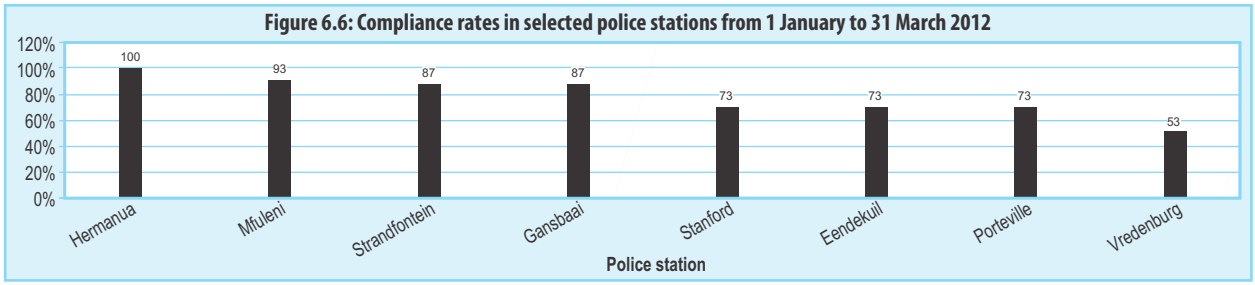
Source: DVA Report: July 2011-March 2012 Department of ICD.

Of the 17 stations audited, only Gugulethu station was fully compliant. Three police stations were 93% compliant, followed by Malmesbury which was 87%. Three stations were 80% compliant, with five at 73%. One police station was 67% and another 60% compliant. Two of the police stations, namely Cloetesville and Harrare, were less than 50% compliant (47% and 40% respectively).



A Victim Friendly Room is designed to make victims of crime feel at ease was relaunched in Gugulethu Police Station. *Photo: cityvision.mobi*

[72] Ibid.



Source: DVA Report: July 2011-March 2012 Department of ICD[73].

Figure 6.6 shows the compliance rates of the eight police stations that were audited from January to March in 2012. Of these only one, Hermanus station, was fully compliant to the DVA. Vredenburg recorded the least compliance rate at 53%.

Some of the findings that spoke to non-compliance pointed largely to poor record keeping and administration, e.g.:

- No updated list of service providers in each vehicle utilised to attend to complaints;
- Responses to domestic violence incidents not recorded on SAPS forms 508 (a) and in DV Register 508 (b);
- The SAPS 206 (member's pocket book) not maintained;
- Monthly procedures of File 39/4/2/3 on DVA incidents (returns) not maintained;
- Procedures of SAPS 10 (occurence book) on DVA not thoroughly maintained;
- Protection orders are not served (no zero outstanding protection orders);
- Copies of protection orders received not filed;
- Copies of warrants of arrest received not filed.

Adapted from DVA Report: July 2011-March 2012, Department of ICD[74]

Overall, it is evident that police stations in Western Cape are not complying with the DVA as is expected. This despite the presentation by SAPS on multi-sectoral interventions and actions on GBV highlighting that the SAPS training academies have a module on the DVA that capacitates all entry level police members in dealing with domestic violence and other gender-based criminal cases. Also, in-service training takes place annually in all provinces in respect of the DVA. Furthermore, capacity building workshops are conducted to empower employees dealing with victims of GBV. Despite such efforts to capacitate the police, it is surprising that the compliance rates are relatively low, particularly in Western Cape. As such, it is recommended that the quality of training be looked at so as to ensure higher quality training.

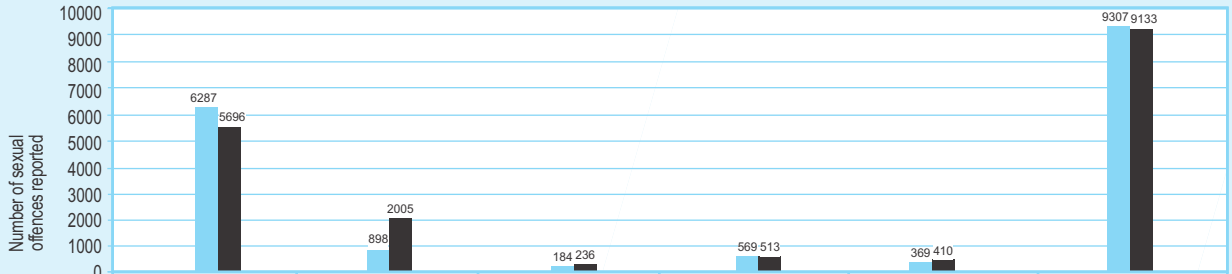
There is also a great need to strengthen internal and external monitoring and evaluation of SAPS response mechanisms to gender violence, and for the corrective measures to be implemented as a matter of urgency. This will enable the SAPS to respond effectively and efficiently to gender violence.

Reporting of sexual offences against women and children to the SAPS in 2011-2012

The overall national sexual offence rates have demonstrated a decrease of four percent from 2011 to 2012, according to the SAPS National Crime Report of 2011/2012. 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 three percent from the previous year (SAPS National Crime Statistics Annual Report 2011/2012).

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

Figure 6.7: Changes in the overall sexual offences in the Western Cape between 2011 and 2012



	Rape	Sexual assault	Sexual offences detected by police	Other contact sexual crimes	Attempted sexual offences	Total sexual offences
2010/2011	6287	898	184	569	369	9307
2011/2012	5969	2005	236	513	410	9133

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

Figure 6.7 shows the different forms of sexual offences that were reported in the year 2011/2012 in Western Cape. Rape was the most dominant type of sexual offence with 5969 cases (65%) reported. Sexual assault constituted 22% of the total sexual offences while other sexual offences constituted 6% and attempted sexual offences constituted5%. Sexual offences detected by police contributed only 3%. It also shows a slight decrease in the total sexual offences incidence between the 2010/2011 and 2011/2012. Overall, Western Cape experienced a 2% decrease in total sexual offences. Thus there was not much difference in the numerical profile of sexual offences between the years 2011 and 2012.

Table 6.2: Western Cape sexual offences incidence rates for females between 2011- 2012

Type of sexual offence	Number of cases 2011/2012	Midyear population (females) 2011	Incidence rate females
Rape	5969	2242086	2.7
Sexual assault	2005	2242086	0.9
Sexual offences detected by police	236	2242086	0.1
other contact sexual crimes	513	2242086	0.2
Attempted sexual offences	410	2242086	0.2
Total sexual offences	**9307**	**2242086**	**4.1**

The incidence rate of sexual offences for the adult female population was 4.1, meaning that four in every 1000 females experienced a form of sexual offence in 2012. This rate is slightly higher than KZN which was 3.2 for the same period. These statistics are relatively low compared to figures obtained from the survey, which highlights the known under-reporting of sexual offences at police stations.

Department of Justice & Constitutional Development

the doj&cd
Department:
Justice and Constitutional Development
REPUBLIC OF SOUTH AFRICA

The primary mandate of the DOJ&CD is to provide court services and ensure access to justice. The DOJ&CD plays a role in the implementation of the DVA and the SOA. DV divisions that provide services for victims of DV are found in all 476 magistrate's courts. Six of these courts provide dedicated DV services.

Similarly, 298 regional courts are dedicated sexual offences courts (SOCs) that offer special services to victims of sexual violence. However, there are 15 SOCs and six family courts that offer exclusive specialised services.[75] In response to the recommendation made by the Ministerial Advisory Task Team on the Adjudication of Sexual Offences Matters (MATTSO) that the SOCs should be re-established in South Africa, the DOJ&CD has commenced the re-establishment of these courts. It is anticipated that the project will be stretched over three years and 57 regional courts will be upgraded to meet the requirements of the new developed SOC model.[76]

The Role of Criminal Justice system

The court-based support services to victims of DV and SO include:

Intermediary services

Intermediary Services provided in courts offer specialised support to a witness by conveying questions in a sensitive manner that ensures the witness understands. Nationally there are 164 intermediaries employed by the DOJ&CD, 24 of them are based in Western Cape.

In-camera court support services

In compliance with the law, the department offers in-camera proceedings to ensure that the victim testifies in a separate room from the courtroom and away from the physical presence of the accused. The main reason for this is to save the victim from secondary trauma. In showing commitment to the capacitation of specialised services in sexual offences and in creating child friendly courts, the DOJ&CD commits funds to the progressive procurement of audio-visual court equipment and the establishment of witness testifying rooms every year. By the end of the year 2011/2012 the following items had been supplied:

- 335 closed-circuit television cameras;
- 49 one-way mirrors;
- 225 child witness testifying rooms;
- 195 anatomically correct dolls



Maria Goosen, Western Cape SAPS forensic social worker for the Family Violence, Child protection and Sexual Offences units, holds a forensic doll.
Photo: Jason Boud

These dolls were purchased 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).

In 2011, the Shukumisa campaign monitored 28 courts in the provinces of Gauteng (5), the Western Cape (4), Limpopo (11), the Eastern Cape (7) and KwaZulu-Natal (1) to assess the availability of these services. They found that 64% of courts had witness waiting rooms; 88% of courts had CCTV facilities; and 36% of courts had a room/office for NGO use.[77]

[75] DOJ&CD: Project on investigating expenditure relating to GBV: Questions.
[76] Ibid.
[77] http://www.shukumisa.org.za/wp-content/uploads/2013/04/Shukumisa-Campaign-submission-DoJCD-NPA-13-April-2013.pdf

Court accompaniment services

The DVA allows victims of DV to testify with the support of not more than three persons in order to minimise secondary trauma during court proceedings. As such, the DOJ&CD urges victims to come to court with their support persons where necessary.

Witness court preparation services

These services are offered by the court preparation officers to familiarise the witness with the court process and to prepare the witness for court.[78] Currently the department relies on the National Prosecuting Authority (NPA) for the provision of these services. The monitoring undertaken by Shukumisa (2011) found that none of the 28 courts assessed had been afforded this service, with only 56% of courts having court preparation officers. The assessment also found that in establishing court preparation services, the DOJ&CD had broadened the service to all victims of crime, thus to some extent defeating the purpose of courts specialising in sexual offences and child abuse matters.[79]

Communication and information dissemination

The DVA imposes specific duties on both the police officers and the clerk of the court to provide relevant information to the complainant. It clearly specifies that in the event that the complainant does not have a legal representative, the court clerk is mandated to provide information on the DVA to the complainant. A study undertaken by GAP and MRC (2001) on the impact of the DVA on women in Western Cape reported that the majority of women who participated in the study described the courts to be very busy, with the clerk "not having time to help".

More than a decade later a study by TLAC in Gauteng found that the court clerks were not as helpful as they were expected to be. It was established that the police were equally negligent in their duties to assist victims of violence. The responses of the women at public hearings confirmed that they were not receiving the necessary information (Watson, 2012). The study also found that there were no proper monitoring and evaluation processes to check whether DVA information was being disseminated.

Another issue that came to the fore was the lack of information about applications for a protection order, recovering one's personal belongings from home and getting assistance in obtaining basic medical treatment. Plans to address this issue are being pursued with other partners in the Justice, Crime Prevention and Security Cluster (JCPS) to finalise a joint JCPS domestic violence strategy.

Record keeping

The clerk of court receives applications and affidavits for the purposes of a protection order application, and then submits the application to court. When protection orders are granted, the court must authorise a warrant of arrest and if it expired or is lost, make available a replacement of the warrant at the complainant's request. The court is expected to keep a file containing all court processes, affidavits and evidence taken to effect the application of a protection order. These maybe used in prosecution purposes, appeals, as well as in other court proceedings such as divorce and custody matters. The study by TLAC in Johannesburg, Mpumalanga and Western Cape established that files kept by the clerk of court on domestic violence incidents are often inadequate and incomplete. This impinges further on actions that may need to be taken in regards to the protection of victims.[80]

Issuing of protection orders

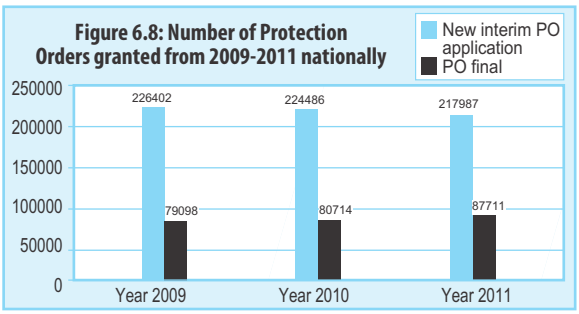
The duties of the magistrate in domestic violence cases are set out both in the DVA and the regulations of the Act. Broadly, the role of the magistrate in domestic violence cases is to:

- Issue *ex parte* interim protection orders if the court is satisfied that there is *prima facie* evidence that a respondent (the accused) has committed an act of domestic violence and that undue hardship may be suffered by an applicant (complainant) if a protection order is not issued immediately.

[78] DOJ&CD, Project on investigating expenditure relating to GBV: Questions to DOJ&CD.
[79] http://www.shukumisa.org.za/wp-content/uploads/2013/04/Shukumisa-Campaign-submission-DoJCD-NPA-13-April-2013.pdf
[80] http://www.tlac.org.za/wp-content/uploads/2012/01/Implementation-of-the-Domestic-Violence-Act.pdf

- Grant final protection orders in cases where the court is satisfied that proper service of the interim order with the return date to court has been effected, and that the application contains *prima facie* evidence that the respondent has committed or is committing an act of domestic violence.[81,82]

After the public hearings held by the Portfolio and Select Committees on Women, Children and Persons with Disabilities, the DOJ&CD was requested to provide information on how many interim protection orders were issued in the period 2010/2011 as well as the number of final protection orders issued in the same period. The results are shown in the figure below.



Source: http://www.shukumisa.org.za/wp-content/uploads/2013/05/Justice-and-DVA.pdf

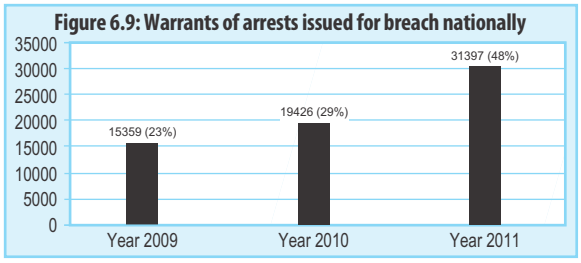
Figure 6.8 shows that there is a huge gap between the number of interim protection order applications and the number of final protection orders granted. Also notable is that from 2009 to 2011, the number of interim orders being granted decreased while on the other hand the number of protection orders made final slightly increased. The DOJ&CD provided possible reasons for the difference in the number of interim protection orders applied for and the final ones granted as follows:

- The loss of interest of the complainant, which is often due to reconciliation with the respondent;
- Sudden lack of co-operation by the complainant or witness, including refusal to testify;
- Respondent or complainant being untraceable;
- Instances where the court, after hearing or considering evidence, cannot find, on a balance of probabilities, that the respondent has committed the alleged acts of DV.

It is interesting to note that the DOJ&CD cited the reason for loss of interest as due only to reconciliation with the respondent, overlooking the fact that many victims lose interest due to the negative attitudes they receive from the justice staff.[83] According to Watson (2012) the criminal justice system triggers a form of secondary victimisation which deters victims from taking the application for a final protection order further. This came out as a critical reason for high attrition levels in the submissions made to Parliament.[84] A study carried out by TLAC found that institutional barriers are playing a role in preventing many women from obtaining due protection from the law. Some courts were less likely to finalise protection orders. This could indicate prejudice on the part of some magistrates towards applicants.[85] As such the department needs to relook at the reasons for high attrition and devise ways to address it, including quality training for the personnel.

Authorisation of warrant for arrest

Whenever the court issues a protection order, the court must make an order authorising the issue or cancellation of a warrant for the arrest of the respondent, depending on the compliance of the respondent. Figure 6.9 shows the number of arrests issued for the breach of the protection order from 2009 to 2011.



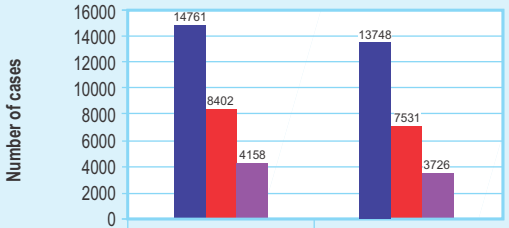
Source: http://www.shukumisa.org.za/wp-content/uploads/2013/05/Justice-and-DVA.pdf

[81] Section 5(2) of the Domestic Violence Act (116 of 1998).
[82] http://www.ghjru.uct.ac.za/osf-reports/magistrates-report.pdf
[83] http://www.mrc.ac.za/gender/domesticviolence.pdf
[84] http://www.shukumisa.org.za/wp-content/uploads/2013/05/Justice-and-DVA.pdf
[85] http://www.tlac.org.za/wp-content/uploads/2012/01/Implementation-of-the-Domestic-Violence-Act.pdf

Figure 6.9 shows the number of warrants for arrests issued from the year 2009 to 2011. Warrants for arrests increased from 23% in 2009 to 29% in 2010, then to 48% in 2011. This increase could mean that more perpetrators were breaching protection orders, leading to more arrests, which would indicate a worrying trend. However, this could also mean that the police have increased their efficiency in arresting those who breach protection orders. Thus it is imperative to research the reasons for this increase.

Some domestic violence victims choose to pursue a criminal case. The figure below demonstrates the criminal prosecutions of domestic violence from the period 2010 to 2011.

Figure 6.10: Criminal Prosecutions from 2010-2011



	Year 2010 Finalisation rate 28% Withdrawal rate 57%	Year 2011 Finalisation rate 27% Withdrawal rate 55%
New matters	14761	13748
Withdrawn matters	8402	7531
Finalised matters	4158	3726

Figure 6.10 shows that the number of new DV criminal prosecutions decreased from 2010 to 2011. The finalisation rates remained low throughout both years, with a slight difference in the rates (28% in 2010 and 27% in 2011). Withdrawal rates remained high over the two years with more than half of the cases being withdrawn in both years. Also notable is the high number of new cases, compared to the low number of finalised cases. In 2010, after 8402 cases were withdrawn, 6359 cases remained. Of these, 3 726 cases were finalised. A total of 2 633 cases was therefore not finalised in 2010. In 2011, 7 531 cases were withdrawn, and of the remaining 6 217 cases, 3 726 were finalised, leaving a total of 2 491 cases not finalised. The DOJ&CD needs to report on the reasons for cases not being finalised so that necessary response may be devised.

Court services

The DVA specifically states that the courts may be accessed for protection order applications any time of the day. However, not all courts adhere to this provision. Some only assist applicants for a few hours every day, or selected days of the week. Commenting on this matter during the public hearings the DOJ&CD argued that the relevant specification provided by the DVA should not be construed as fully operational 24-hour courts. It also highlighted that this provision was available in exceptional instances. In such instances the magistrate courts give the SAPS a roster of officials who are on call to assist in protection order applications after hours (Watson, 2012).

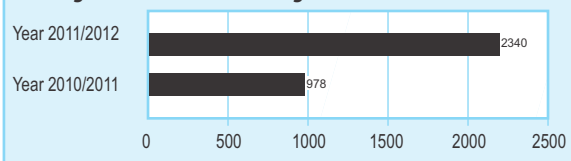
National Register for Sex Offenders

The National Register for Sex Offenders (NRSO) is a database containing particulars of persons convicted of any sexual offence against a child or a person who is mentally disabled, or 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 persons who are mentally disabled against sexual offenders by establishing and maintaining a record of persons who have been convicted or alleged to have committed sexual offences.

Source: http://www.justice.gov.za/vg/nrso.html

Figure 6.11: Number of registered sexual offenders



	Year 2010/2011	Year 2011/2012
% increase		139%
Number	978	2340

Table 6.11 clearly shows a progressive increase of 139% in the registration of offenders during 2011/12. Over this period, the Registrar received a total of 39 684 names of historical convictions from the SAPS. These were the first ever submissions of such convictions made to the Registrar, and were therefore considered to be a huge breakthrough in the registration of this data. Unfortunately, data from other sources that had been identified was not received for record in the DOJ&CD annual report, 2011-2012.

Conclusions

This chapter outlines the response structures that have been put in place to assist the victims of GBV. South Africa can be commended for being progressive and partaking in various international conventions that protect the rights of women and combat GBV. The DVA, SOA and more recently the Sexual Harassment Act, are the major policies that directly address GBV by placing responsibilities on various departments to ensure a holistic response system. Despite such progressive and comprehensive interventions, however, there is still a glaring gap between what is written on paper and actual implementation. As in many settings, laws and policies are not accompanied by adequate resource allocation for effective implementation, and as such, actual implementation is impeded.

The SAPS, criminal justice, social services and the medical sectors have made significant strides in establishing specialised structures that focus on the victims of GBV. However, lack of adequate resources hinders progress. This is exacerbated by lack of monitoring and evaluation frameworks to guage progress in the implementation of these processes.

This study recommends that explicit budgets be allocated to each and every policy and structure so as to enable implementation. Equally important is the need to erect independent bodies that monitor implementation as well as compliance of the respective stakeholders. It is imperative that response mechanisms provided by the health, police and criminal justice system as a primary prevention of violence are strengthened.[86]

Also evident in the study is that a significant number of women are not aware of the laws. More men proved to be more knowledgeable about the existing laws that protect women. This clearly shows that the current structures and measures are not adequately assisting the victims of violence. Furthermore, based on the high level of GBV experienced in the communities, there is need to undertake a paradigm shift from a responsive to a more proactive stance.

[86] http://whqlibdoc.who.int/publications/2004/9241592079.pdf

CHAPTER 7
SUPPORT



TAC EDEN & BITOU Municipality join forces against Gender Based Violence. *Photo: Google Images*

Key facts

- The Victim Empowerment Programme (VEP) aims to offer support to survivors.
- Non- government organisations currently provide an estimated 60% of social welfare services to women and children.
- There are 18 shelters in Western Cape, of which 50% are funded by the government through the Western Cape DSD.
- Alternative funding comes from churches, community chests and individuals.
- Shelters are a form of short-term intervention where survivors are given accommodation for a specified period of time.
- Lack of funding has negatively affected provision of support services in shelters.
- The Saartjie Baartman Centre offers support to survivors of domestic violence and sexual violence, and has partnered with other organisations to offer holistic integrated services to survivors of gender violence.
- Sister Incorporated is a private organisation that started offering support to survivors of gender violence and rape survivors in the late 1980s.
- St Anne's shelter has evolved to be a sustainable project which offers support through empowering survivors of gender violence and other women.
- A provincial policy and standardised guidelines in the management of rape survivors were developed under the Ministry of Health in the Western Cape Province in 1999.



"My name is Romalia. I was 15 years old when I met my husband Sam. He was the sweetest and most loving man I had ever met and I immediately knew that he was going to be my life partner. At 16, I fell pregnant with my first child. I was both afraid and happy that Sam* and I were going to be parents. When I told him, he was upset and he asked if I was sure he was the father. He started swearing at me on the phone and asked me not to phone him again. I told my mother who immediately went to Sam's mother and they made the wedding arrangements. My mom, who is very religious, did not mind the fact that I was still a minor. She had us married the traditional way.

Sam started drinking heavily and shouting and insulting me, saying that my mother had forced him to get married. I was three months pregnant when I lost my first child. Sam left me alone at home the day I came back from hospital and he returned at 3:00 in the morning. I asked where he was and he started shouting at me and pointing fingers in my face, blaming me for the loss of our child. He spat in my face and told me I was not worth being called a woman. I cried the whole night while he slept. The next day he took me out and apologised, and the next few months went by with no abuse.

One weekend Sam asked me to go with him to his mother's house and as I got dressed he started laughing and making fun of me. Once I was dressed, I told him that I would rather stay because I was not feeling well, and he shouted at me asking if I had another man coming to the house. When Sam came back home that evening, he made me undress have a shower because he said he didn't want another man's disease.

I fell pregnant again for the second time and had a healthy baby boy. I was so proud. Sam came home late with his friends, and he wanted to show them the baby. He asked for some money and when I refused, one of his friends laughed at him. He asked them all to leave. He grabbed me by my hair and sexually assaulted me to punish me, saying he'd show me who the man in the house was. I honestly thought I was going to die.

After I gave birth to my second child Sam started insulting me about my appearance, telling me how fat and ugly I looked. Every time I dressed he told me I looked like a slut. One Friday, Sam came home drunk and said he had just been robbed and there were no wages that week. I started crying because I knew he was lying, and he grabbed me by my hair, put his hand around my neck and started squeezing it so hard I felt my breath slowly leaving my body. Just as I was going to pass out, he let me go. I don't remember much about that day. The next day, I left my kids at my mom's house and took the next taxi out of Cape Town. I ended up in George and stayed there for two months until my mother passed away. I returned home to look after my four siblings and two children. My husband moved in with me, promising he would never hit me again but things didn't change. He began insulting me and his drinking got heavier.

One day he came home drunk while I was sleeping in the children's room. He lifted the mattress and dropped us all on the floor. He laughed about it and my children started crying. After I got them to sleep, I went into my bedroom because I didn't want him to disturb them again. He was asleep when a message came through to his phone and I read it. I found out he was having an affair. He grabbed his phone when I confronted him about the message. He told me that I was stupid and shouldn't read his messages. We started arguing and he smacked me, and I hit him back. He grabbed me, shook me so hard that I could hear my body making funny sounds. He then pinned me down on the bed and was about to punch me when I heard my son scream. Sam let me go, went straight into his car and drove away. I looked at my children's faces that night and realised what I was doing to them. I never hated myself as much as I did that night.

I contacted their school the next day and asked if they were allowed to stay at home. I think the Principal heard something in my voice and asked me to come into her office immediately. She told me to call the

Saartjie Baartman Centre. Here I have peace, respect and solace. Here, I have learnt to appreciate myself and my children. I love them and devote my time to them."

Romalia was sexually, economically, emotionally and physically abused by her intimate partner. He used violence as a means to claim control and show power. He also used violence as an expression of his reluctance or refusal to take responsibility for the pregnancy. Romalia eventually got help from the Saartjie Baartman Centre where she receives all the support she needs.

This chapter explores the adequacy, accessibility and effectiveness of support systems and structures set in place to respond to survivors of GBV in the Western Cape Province. Case studies provided in this chapter help to illustrate the support given to survivors of gender based violence in the province as well as identify gaps in the support being given.

Definition of support

Survivors of GBV face enormous challenges in accessing facilities for reporting, treatment, counselling, and safe shelter. The 365 Day National Action Plan of 2007 prioritises support for GBV survivors, and stipulates that support for victims comes in the form of providing shelters as well economic empowerment for the victims and survivors of violence. The plan recommends advocacy and lobbying on the links between GBV and economic development and also discusses with relevant stakeholders ways of challenging patriarchal systems and their oppression of women.[87]

South Africa has set up structures that are mandated to ensure that survivors of GBV are supported. This report highlights the importance and relevance of the Victim Empowerment Programme.

National Victim Empowerment Programme

The National Victim Empowerment Programme (VEP) was established as a key feature of the National Crime Prevention Strategy (NCPS), which was a proposed strategy to address the factors that contribute to the high levels of crime in South Africa.

The VEP focuses on promoting a victim-centered approach to crime prevention. It is also based on a partnership between national, provincial and local government departments and civil society organisations, volunteers, the business sector, and academic and research institutions. The purpose of the VEP is to facilitate the establishment and integration of inter-departmental/inter-sectoral programmes and policies for the support, protection and empowerment of all victims of crime and violence with special focus on women and children (VEP 10thAnnivesary Conference, 2008).

Table 7.1: National performance indicators of the VEP

National Indicators	2010/2011	2011/2012
Number of shelters for victims of crime and violence funded	12	12
Number of victims of crime and violence in funded VEP shelters	2832	5860
Number of victims of crime accessing funded VEP services	20232	29955
Rand value of funds transferred to funded VEP shelters	R 3.5m	R4.0m

Source: Western Cape DSD Annual Report, 2011/12 .

Table 7.1 shows that from 2010 to 2012, the DSD funded 12 shelters for victims of crime and violence. Currently there are 18 shelters in the province. During this period, the number of victims of crime and violence in DSD-funded VEP shelters rose from 2832 to 5860, while the number of victims accessing the

[87] GBV Indicators research KZN Report, 2013.

shelters rose from 20232 in 2010 to 29955 in 2012. The picture that emerges here is that the demand for resources is outweighing the supply, thereby putting tremendous pressure on the existing resources. The number of victims in need of shelters doubled while the number of shelters remained stagnant. The Department increased the amount of money allocated to the shelters by 14% from R3.5m to R4m. This indicates the need for a paradigm shift with a focus more on prevention rather than cure. Efforts to keep up with the victims of crime will eventually wane if preventive measures are not put in place.

Western Cape Department of Social Development's VEP

The WCDSD has a social welfare services programme which provides integrated development services to the poor and vulnerable. The programme is implemented in partnership with stakeholders and civil society organisations. Within this programme are ten sub-programmes focused on victim empowerment and crime prevention and support. This study looked at these sub-programmes.

Historically, the VEP programme focused on victims of domestic violence, sexual assault and rape. Over the years, however, it has noticed a need for services that extend beyond these categories and hence the programme plans to integrate services that support all victims of VAW. The aim of the VEP programme is to sustain existing shelters and improve quality of services to victims of crime. It will initiate interventions aimed at the prevention of GBV and progressively mainstream gender issues in all departmental programmes.

Victim support services are spread across government departments due to various legislative mandates. However, services are often uncoordinated, with victims seeking assistance being sent from one service point to another, with the unintended consequence of causing re-victimisation. One of the aims of this programme is to enhance inter-departmental co-ordination of these services across various levels of government. A provincial co-ordinating forum has been established and sub-forums in all six regions will also be established.[88]

Table 7.2: Provincial performance of the VEP programme

Performance Indicators	2010/2011	2011/2012
Number of victims of crime and violence who received counselling at DSD local offices	2566	630
Number of VEP awareness campaigns implemented	7	62
Number of functional regional VEP inter-sectoral coordinating forums	6	2
Number of youth attended and completed gender violence prevention programme	300	2353

Source: Western Cape DSD Annual Report, 2011/12 .

Table 7.2 shows the targets set against the actual output. The target for the number of victims receiving counselling at DSD local offices was not reached because not all regional forums were operational. The number of VEP awareness campaigns implemented was more than the target because more campaigns were held by NGOs. As a result of human resources challenges, the set target for the co-ordinating forums could not be met. The increase in the number of youth attending the gender violence prevention programme rose from 300 to 2353. This is attributed to the successful awareness campaigns launched by the regions.

[88] Western Cape DSD Annual Report 2011/12.

Table 7.3: Departmental performance indicators for April 2010-March 2011	
Indicator	**Performance evaluation**
Number of shelters for domestic violence managed by NGOs	12
Number of persons residing in registered shelters for victims of domestic violence managed by NGOs	1365
Number of children residing in registered shelters for victims of domestic violence managed by NGOs	1067
Number of victims participating in at least one programme within shelters for victims of domestic violence managed by NGOs	1805
Number of counsellors working in shelters for domestic violence managed by NGOs	21
Number of victims of domestic violence assisted with protection orders	10223
Number of sexual violence cases dealt with	6244
Number of perpetrators involved in perpetrator programmes	105

Source: Western Cape DSD Annual Report, 2011/12 .

Table 7.3 shows the performance evaluation for the DSD from 2010 to 2011. The DSD is generally overwhelmed by huge numbers of women and children who require assistance at shelters. The number of women assisted with protection orders as well as the number of sexual violence cases that were dealt with are relatively high, indicating the magnitude of GBV cases in the province. With only 12 shelters and 1365 people residing in these shelters, it means on average that each shelter served 113 women and 89 children. Looking at the number of counsellors, it is evident that the shelters are short-staffed.

The province's DSD is mandated to design and implement integrated programmes services to support, care, and empower victims of violence and crime, in particular women and children.

Shelters for Abused Women

Survivors of gender violence are entitled to be placed in a safe 'home' during times of vulnerability. Shelters are a form of short-term intervention where survivors are given accommodation for a specified period of time. Women are usually referred to shelters as an early intervention. The SAPS is tasked by the DVA to refer and transfer survivors of gender violence to shelters, relative to need.[89] The shelter intervention provides basic needs (clothes, food and housing), empowerment through counselling, capacity building, skills training and protection from abuse. These services are meant to embark women on a healing exercise as well as help them become empowered so that they do not go back to abusive environments. Shelters for abused women can be categorised in three different stages, namely:

First stage: This is a basic emergency housing facility which offers short-term accommodation, and usually ranges from three to six months.
Second stage: This accommodates abused women for a period ranging from six to 18 months, usually after the first stage shelter. This facility offers greater level of support. Counselling and skills support is offered to prepare the women to move to the third stage housing and possibly find employment.
Third stage: This is more secure and offers permanent housing for women leaving the second stage. However, there is a severe shortage for such housing for survivors in the Western Cape and the country at large.[90] Community housing projects offer a form of third stage housing where survivors stay in shared facilities and rentals are low.[91]

The Minimum Standards on Shelters for Abused Women offer a guideline on how shelters should operate in providing support to survivors of gender violence.[92] These guidelines cover programmes of

[89] http://www.za.boell.org/downloads/Gauteng_Shelters_Report.pdf
[90] http://www.csvr.org.za/docs/gender/handbook.pdf
[91] Ibid.
[92] Minimum Standard on Shelters for Abused Women.http://www.endvawnow.org/uploads/browser/files/minimum_standards_southafrica_2001.pdf

empowerment, family-centred and community centred interventions, and confidentiality. However, one of the shortfalls of the guidelines is addressing the breakdown of families in cases where the abused woman has male children above 12 years of age. The psychological damage brought about by family separation cannot be over emphasised (TLAC, 2012). Additionally, children who accompany women to the shelters are not receiving adequate services.[93]

One of the main shortfalls in provision of support to survivors is that the available shelters do not meet the demand for shelters by survivors of gender violence. Certain shelters can accommodate only a limited number of women. Shelters like the Saartjie Baartman Centre (SBC) and St Anne's house about 20 to 25 women at a given time.

Shelters also lack adequate financial resources to effectively provide support to GBV survivors.[94] According to the Saartjie Baartman Centre (SBC), increased financial resources enable them to increase the number of beds they offer to survivors. The government has pledged to offer some financial support though shelters are disgruntled about the minimal funds provided.[95] About 60% of social welfare services for women and children are run by NGOs.[96] Shelters in Western Cape have sought other means to sustain themselves, such as making survivors pay subsidised rentals. Government needs to increase its political will towards supporting survivors of gender violence. Budgets need to be increased and funds allocated timeously. The community also needs to understand its social responsibility to contribute to the rehabilitation of survivors of gender violence. Thus, the community should be encouraged to offer help in the running of the shelters.

Shelters in Western Cape

There are 18 shelters in Western Cape[97], of which 50% are funded by the government through the Western Cape DSD. Alternative funding comes from churches, community chests and individuals. Three case studies of shelters found in Western Cape are presented in this chapter.

Saartjie Baartman Centre

The Saartjie Baartman Centre for Women and Children (SBC) was established in 1999 as the first one-stop centre for women, youth and children in South Africa. The main purpose of the Saartjie Baartman Centre is to provide services which reduce secondary victimisation and facilitate healing and recovery through provision of high quality services. The centre is located in Manenburg in Cape Town, an area which has high rates of substance abuse, child abuse, domestic violence and gangsterism. Because the area is poorly resourced, SBC offers essential services to residents of Manenburg as well as those from other townships, communities and informal settlements. The centre also works with non-profit organisations to provide a range of services for women, youth and children who have experienced domestic violence and sexual violence.

Services at the shelter

- A 24-hour crisis response
- Residential care for abused women and their children
- Specialised counselling services
- Life and job skills training
- HIV/AIDS education
- Legal advice and assistance
- Assistance, training, research, advocacy, education and prevention projects in surrounding communities and schools

On average about 22 women and 35 children stay at the facility for about four months at any given time.[98]

[93] http://www.tlac.org.za/wp-content/uploads/2013/07/Western_Cape_Shelters_Housing_Women_Who_Have_Experienced_Abuse.pdf
[94] http://www.tlac.org.za/wp-content/uploads/2013/07/Western_Cape_Shelters_Housing_Women_Who_Have_Experienced_Abuse.pdf
[95] http://www.saartjiebaartmancentre.org.za/images/docs/SBaartmanAnRep2012pr2.pdf
[96] http://www.tlac.org.za/wp-content/uploads/2013/07/Western_Cape_Shelters_Housing_Women_Who_Have_Experienced_Abuse.pdf
[97] http://www.csvr.org.za/docs/gender/handbook.pdf
[98] http://www.saartjiebaartmancentre.org.za/index.php/services/residential-programme

Table 7.4: Number of people offered services at Saartjie Baartman Centre (1 September 2011- 31 August 2012)

Empowerment	Total
Counselling and awareness raising	**2 409** women
Legal advice and assistance	**1 455** consultations
Community Outreach	**2 649** participants
Job skills and income-generation	**939** job opportunities
Residential	**739** women and children

Table 7.4 shows the main activities of the centre and the number of people who have been helped from September 2011 to 31 August 2012. A total of 739 women and children were given residence at the centre. Empowerment of women is also central to service at the centre. Counselling and raising awareness, legal advice and assistance, community outreach, and job skills and income-generation are four inter-related services provided to empower women.

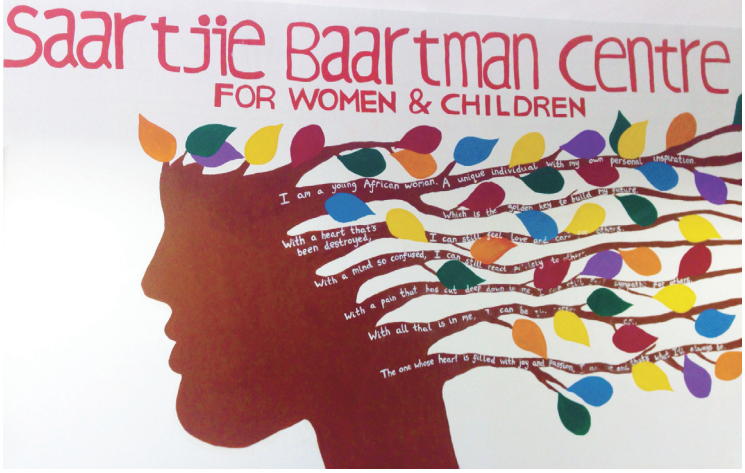
Challenges

- Similar to other shelters, the centre does not receive adequate funding from the government. Again, the government need to strengthen its political will towards supporting survivors and prevention of gender violence, while civil society needs to play a more active role by making donations of time and money towards offering support to women who have suffered violence.
- Demand for accommodation is high, but the centre cannot accommodate all those who need it due to limited space.
- The centre receives high numbers of GBV survivors who abuse alcohol and drugs.

A research paper conducted by a UCT student was used to assess client satisfaction at Saartjie Baartman, and it showed that on average the survivors are happy with the services they receive at the centre. The centre is an excellent example of the one-stop centre model. As testimony to that fact, the centre established a residential care facility in nearby Worcester.



Efforts should be made to create more centres like the Saartjie Baartman Centre as well reinforcing the existing ones. St Anne's in Cape Town is one shelter that has adopted a sustainable approach in providing support to survivors of gender violence. It offers a variety of the three stages of accommodation to pregnant, abused and homeless women and children.[99]



[99] Ibid.

Case Study: St Anne's Home and Place of safety

St Anne's Home and Place of safety was originally formed in 1904 by Anglicans to accommodate girls and women in need. As time went on, the shelter evolved to become a sustainable project which offers support through empowering survivors of gender violence and other women. St Anne's charges rental for the second and third stage shelter. Charging rentals is aimed at promoting self-reliance and ensuring the sustainability of the shelter. The home charges about R450 per month for second stage shelter and R750 per month for third stage shelter.

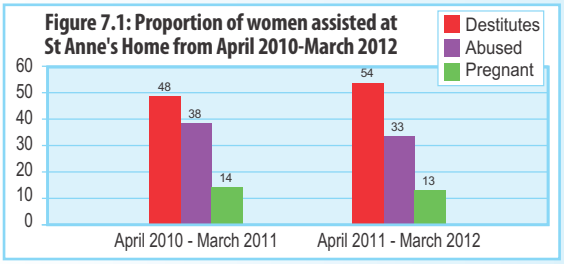


In Celebration of Women's month Heart104.9FM visit St Anne's Home. *Photo: St Anne's Home*

Project Activities

St Anne's is a home that offers a holistic intervention that comprises accommodation, education, counselling, training, spiritual input and community involvement.[100] Skills training programmes that are offered to women include business skills, catering, sewing, beading and jewellery making.[101] Community involvement in management, decision making and problem solving is a strategy used to empower women. The survivors own the committees, organise duty rosters and are consulted regarding day-to-day issues. This empowerment encourages mutual accountability and responsibility between staff and the residents".[102] The survivors also have access to legal advice. Two legal advisors at the shelter assist women with protection orders, maintenance, divorce issues and court preparation.[103]

Figure 7.1: Proportion of women assisted at St Anne's Home from April 2010-March 2012



Fifty one women were assisted at St Anne's during the April 2010-March 2011 period, increasing to 61 women during the April 2011-March 2012 period. Figure 7.1 shows that 38% of the women assisted at the shelter were survivors of abuse during the 2010-2011 period, dropping to 33%during the 2011-2012 period.

"We have also seen abused women returning to their partners or husbands. The tendency for women with many children and no financial means is to take what they consider the easy option and return to the abuse. Luckily there has been positive pinoffs in some cases. With the services we render, these women have empowered themselves and then negotiated a positive return to their partners. We do empower women". Desiree Douglass (Social Worker)

[100] http://www.stanneshomes.org.za/St%20Anne's%20Annual%20Report%202011_2012.pdf
[101] Ibid.
[102] Ibid.
[103] http://www.unicef.org/southafrica/SAF_resources_violenceprevmodel.pdf

Outlined below is another organisation that provides shelter services to survivors of GBV. Sister Incorporated endeavours to offer holistic physical and emotional care to women and children.

Sister Incorporated

Sister Incorporated is a private organisation that started offering support to survivors of gender violence and rape survivors in the late 1980s. However, it does not accommodate women without South Africa citizenship, and women who abuse substances are also not housed in the shelter. It runs a residential facility with a maximum of 28 beds.

Services offered

The following are some of the services offered by the centre:

- Three meals a day, a wash line, toiletries, clothing (underwear, shoes and at least three sets of clothing).
- A social worker at the shelter provides individual and group counselling. Where necessary, the women are referred to external specialists.
- The survivors are provided with medical health care at the cost of the shelter. (Substance abuse, pregnancy, post-partum care, HIV, depression and physical injuries from abuse are some of the medical health care conditions survivors need help with.)
- Skills training in computer literacy, jewellery making, beading, knitting, sewing and fabric painting among others.

Impact of Shelters

It is commendable that despite operating with minimal financial budgets, shelters have a positive impact on the lives of survivors of violence. Empowerment of survivors is a central issue in the three case studies presented in this chapter. Various empowerment approaches such as formal education, skills development and economic empowerment equip women to fully participate in their communities. Empowerment leads to an improved standard of living. It is assumed that if a woman is economically empowered she is less likely to return to the abusive relationship. Research shows that survivors who are emotionally and economically dependent on their abusers are more likely to go back to the abusive relationship.[104] These three case study in Western Cape show that about 32% of the women did not return back to their abusers due to the empowering services they received.[105] Additionally, a study shows that women who participated in empowerment programmes exhibited greater self-confidence, more influence over household decisions and were better able to challenge traditional gender norms. These women were less likely to experience sexual violence.[105]

Other than offering a temporary place of safety for survivors, shelters in the province endeavour to offer psycho-social support, which is critical for recovery.

Access to health services by survivors of gender violence

Gender violence has serious negative consequences in respect of the health of women. Studies have documented the sexual reproductive health and mental health burden which arise as a result of gender violence (Dunkle 2003, Matthews 2004). A survey conducted by the South African Medical Research

[104] Gender Links, Regional Barometer, 2014.
[105] http://www.tlac.org.za/wp-content/uploads/2013/07/Western_Cape_Shelters_Housing_Women_Who_Have_Experienced_Abuse.pdf
[106] http://www.unicef.org/southafrica/SAF_resources_violenceprevmodel.pdf

Council in 2004 on rape survivors found that the survivors were not receiving adequate health care support. About a third (33%) of health care providers did not consider rape to be a serious medical condition, and only 30% had received any form of training in caring for rape survivors. As a result, the majority of practitioners never considered referring survivors for counselling. Only 20% of the practitioners surveyed offered post-exposure prophylaxis (PEP) to survivors of rape (Christofides 2005). As such, there is need to capacitate health service personnel to render adequate support to survivors of violence as well as make appropriate referrals.

The DSD explicitly stipulates that survivors of gender violence should receive comprehensive medical support as well as other forms of support. As highlighted in Chapter 5 of this report, health care facilities are often the point of first and only contact for women (Martins & Jacobs 2003). According to the Western Cape Department of Health Report, there are 52 healthcare facilities in the province that are dedicated to the management of children and adults who have been abused. From 2011 to 2012, 38 798 people were reached by support groups.

The Ministry of Health in the Western Cape developed a provincial policy and standardised guidelines in the management of rape survivors in 1999.[107] In 2000, it was modified to include the provision of PEP. The document stipulates that for a healthcare provider to provide support to survivors of rape and sexual assault, the following must be available:

- Private/designated room area at a 24-hour service centre;
- Access to emergency care;
- Equipment to perform forensic examination such as pus swabs, slides, tubes for blood sampling, combs, nail scissors;
- Adequate stationary, pre-printed management guidelines (Addendum A), referral letters and an affidavit for crime kits to ensure that chain of evidence is not broken;
- Lockable cupboard and register for forensic evidence;
- AZT-Register and pre-printed forms (Addendum B);
- Access to a telephone and fax machine;
- Medical cupboard stocked with packaging containing:
  a) Emergency contraception
  b) Syndromic management for the prevention of STIs as per guidelines
  c) Analgesia anti-inflammatory, or
  d) Tranquilizers in individual circumstances (may cause problems as it can affect memory of the incident)
- A traditional cup of tea for alleviating shock;
- Access to bath or shower or toilet facilities;
- Emergency clothing and or underwear, sanitary towels, soap and towels;
- Posters, pamphlets and information about rape, counselling and human rights;
- Directory or list of local resources;
- No patient should be turned away to seek help from another institution;
- All documents must be treated confidentially;
- Survivors should be given the option of going for counselling. This can be to a social worker, trained counsellor, private therapist, e.g. psychologist. All rape survivors are to be interviewed by the appropriate healthworker in a private room. It is advisable that a trusted friend, relative or nurse supports him her during the interview, according to the patient's wishes.

(From Survivors of rape and sexual assault: policy and standardised management guidelines in the Western Cape Province)

[107] http://www.westerncape.gov.za/text/2003/survivors_rape_sexual_assault.pdf

Mosaic as an institution offering medical support to survivors



Mosaic is an example of an organisation that focuses on offering medical support to survivors of gender violence in Cape Town. It is an NGO with 70 staff members. It deals with survivors of gender violence so that they find healing and empowerment. Mosaic has two sexual reproductive health clinics situated in Wynberg and Mitchells Plain. The clinics provide services which women often struggle to access at day hospitals or at their own community clinics. Mosaic works in collaboration with the Simelela Centre and the DoH. Medical services offered to survivors include:

- Emergency Medical Care including forensic examinations, STI treatment including PEP, emergency contraception and voluntary testing for HIV/AIDS;
- Follow up medical care which includes 28 days of PEP, HIV testing after six and 12 weeks, referral of HIV positive patients, referral for unwanted pregnancies;
- Psychological Support including initial 'containment' counselling and the option of 12 follow up sessions, and individual counselling for cases of survivors aged 14 years and under and their families.[108]

Mosaic assisted about 1 116 survivors of sexual violence during the 2011/2012 period. About 53% of the survivors came for assistance within 72 hours of being victimised, and 84% of these women received PEP. It is reported that most survivors do not return to the clinic for follow-up after the initial medical support, and about 10% of the women return for the third monthly visit for a check-up.[109]

It is very important that Mosaic offers continual training to its staff members to keep them abreast with developments related to GBV so that they can offer adequate support to survivors. The centre has created a training programme which it aims to develop as a sustainable income generating vehicle. Some training courses offered by the dedicated training unit include half-day workshops, basic counselling skills for lay counsellors, male counselling in the context of intimate partner violence, and child abuse awareness for crèche teachers.

Funding

Mosaic receives 17% of its annual budget from government while most (roughly 80%) of the funding comes from international funders such as The Global Fund and Elton John Foundation.

Outreach

The organisation conducted 56 presentations on sexual violence, reaching 14877 people. Additional figures on outreach are provided below.

Table 7.5: Number of individual counselling sessions per district

District	Number of clients	% of total
Khayelitsha	603	19.80%
Bellville	444	14.58%
Gugulethu	840	27.59%
Mitchells Plain	219	7.19%
Eersteriver	254	8.34%
Cape Town	361	11.86%
Wynberg	324	10.64%
Total	**3045**	**100%**

Table 7.5 shows that a total of 3045 survivors in seven districts received counselling services at the centre.

[108] http://www.westerncape.gov.za/text/2006/11/simelela_one_year_report_optimised_2006.pdf
[109] http://mosaic.org.za/main/wp-content/uploads/2013/07/mosaic_annual_report_20121.pdf

Figure 7.2: Number of clients assisted at the courts

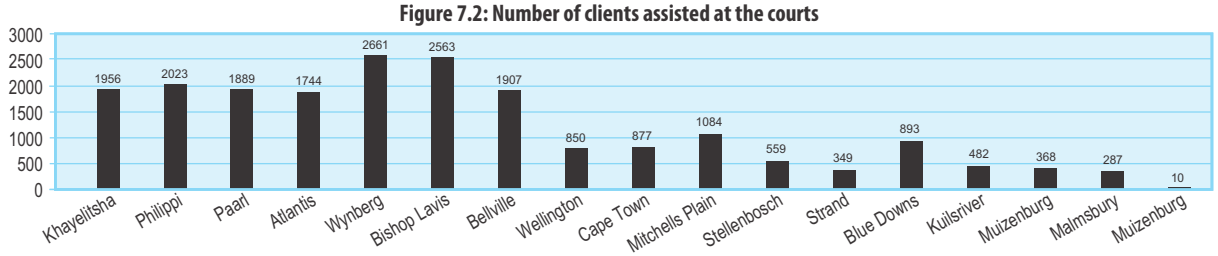


Figure 7.2 shows the number of clients who were assisted at the courts, totalling 20502.

Skills development

The centre runs a kitchen skills programme over a 10 week period which provides survivors with kitchen training. They receive a qualification once the course concludes. This programme is highly effective as it empowers women, teaching them to sustain themselves and continue life as financially independent women.

Challenges

Some of the major challenges include limited human and financial resources, safety for staff in the field, and emotional strain on staff.



Mosaic participants in training. *Photo: Mosaic*

Legal Aid for survivors of gender violence

According to the Service Delivery Charter, the DOJ&CD is mandated to offer support services to survivors of domestic violence. Survivors are not supposed to spend more than two hours in the queue before being attended to, and an interim order is supposed to be issued within a day. A final protection order is expected to be granted within 60 working days following the date of the interim protection order being issued.

Additionally, the SAPS has pledged to offer the following support services in DV courts:

- Treating victims/complainants and their families with respect and courtesy;
- Taking statements in a professional manner;
- Providing victims with information on their case number as well as details of the investigating officer;
- Informing/educating victims about the procedures of the police (investigative) and the criminal justice system;
- Providing advice on crime prevention; Referring victims to medical and/or counselling and support services in the community.

However, survivors often suffer secondary victimisation though the mistreatment they receive in the justice system. As a result, survivors tend to not report offences, preferring to keep it private, or cases are dropped due to fear of further victimisation by the perpetrator or community, the criminal justice system and/or the police.

NGOs like Mosaic and the Rape Crisis Cape Town Trust have seen a gap in the provision of legal aid and justice to survivors of gender violence.

[110] http://www.justice.gov.za/faq/serive-charter.pdf

Case Study: Rape Crisis Cape Town Trust (RCT)

RCT has a vision of a South Africa where the criminal justice system supports and empowers rape survivors in all its interventions with them. Since 1976 the RCT has been empowering women on the road to justice, and supporting them on their journey to recovery.

Figure 7.3: Services at the RCT from 2011 to 2013

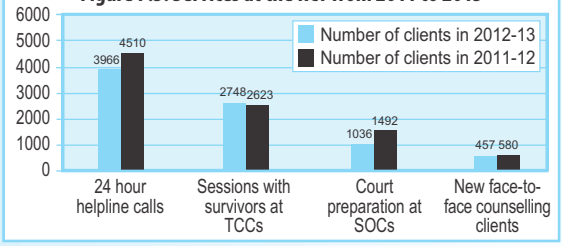
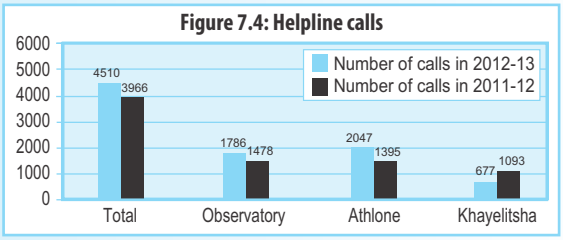


Figure 7.3 shows that from 2012 to 2013, RCT offered face-to-face counselling to 457 individuals and families, gave advice to 3966 callers, served 2748 survivors at two of Cape Town's busiest Thuthuzela Care Centres, and prepared 1036 witnesses at five of Cape Town's sexual offences courts.

Figure 7.4: Helpline calls





Rape Crisis team during the 16 Days of Activism. *Photo: Rape Crisis*

Figure 7.4 shows RCT gave advice through helpline calls to 4510 survivors from 2011 to 2012, and in 2012 to 2013, these calls decreased to 3966. The highest number of calls received in 2011-12 was from Athlone, while in 2012-13 more helpline calls came from Observatory.

Figure 7.5: Face-to-face counselling

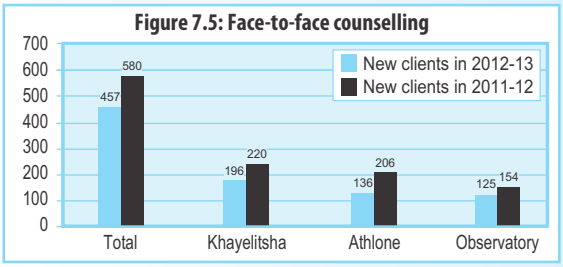


Figure 7.5 shows there were more face-to-face counselling sessions at RCT from 2011 to 2012 (580) compared to the period 2012-2013 when 457 survivors received counselling.

Figure 7.6: Court support

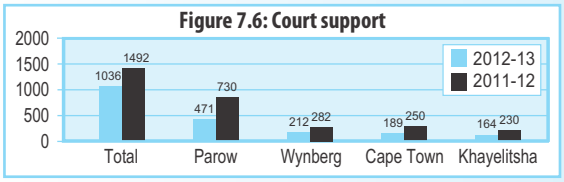


Figure 7.6 shows that RCT assisted 1492 survivors with court support from 2011 to 2012 compared to 1036 from 2012 to 2013. From 2011 to 2013, Parow consistently registered a higher number of survivors compared to Wynberg, Cape Town and Khayelitsha.

Realising that rape survivors were not receiving adequate support services in the justice system, RCT pledged to offer rape survivors support to minimise secondary trauma. Survivors who get support before entering the criminal justice system, and within the criminal justice system, increase the effectiveness of their cases against perpetrators, thus the chances of arrests increase. This is done at four regional courts in Cape Town.

Three pre-trial counselling sessions are given to rape survivors in preparation for trial. Often the survivors are traumatised by having to recount the ordeal of rape. However, the emotional support provided by the RCT gives the survivors strength and courage to go through the legal system. During the 2011/2012 period, the Trust managed to reduce secondary trauma in rape survivors by 67%.

Table 7.6 shows that a total of 1492 rape survivors were assisted in the Cape Town region by the RCT. The Trust commented that this figure exceeded the target it had set for the 2011/2012 by 163 survivors. This implies that there is a huge demand for legal support among survivors of gender violence.

Table 7.6: Number of rape survivors assisted at four courts in Cape Town from 2011 -2012

Court	Number of survivors
Wynberg	282
Parow	730
Khayelitsha	230
Cape Town	250
Total	**1 492**

Conclusion

Various services are available to survivors of gender violence in the Western Cape Province. Shelters, health care and legal aid services are some of the support systems included in the chapter. It is commendable that most shelters, as illustrated by the case studies, strive to offer comprehensive support systems. Other than offering shelter for a specified period, survivors are given psycho-social support which is critical for mental health. Depression and suicide are among the mental health problems which burden survivors of gender violence. For the health care needs of survivors to be adequately taken care of, there is need for the government to invest in more health care providers who are adequately trained to deal with issues of gender violence. In the Western Cape, as in the other provinces, NGOs are at the fore in providing support to survivors of violence, with little or no help from the government. While the efforts made by the various government departments are commendable, there is still a lot of work to be accomplished. The existing support structures are inadequate. There is still a high unmet need for victim centred support for survivors of violence.

Lack of adequate funding is one of the main reasons hindering the provision of adequate support to survivors of gender violence. Thus government needs to increase funding through the Ministries of Health and Social Development. Additionally, awareness should be raised in these ministries as well as the communities regarding secondary victimisation and/or stigmatisation of survivors. Given that NGO funding is dwindling globally, the government needs to take the lead in ownership and provision of GBV support services. The Khuseleka One Stop Centre in the Limpopo province is a best practice that can be replicated in other provinces.

CHAPTER 8
PREVENTION



Woman farm workers, Western Cape. *Photo: Trevor Davies*

Key facts

- The government showed its commitment to addressing GBV by allocating R16 million toward the national VEP in the financial year 2013/2014.
- Eighty three percent of women and 78% of men have heard of the 16 Days of Activism.
- Eighty three percent of women and 54% of men knew of the 365 Days campaign.
- Most women (59%) heard about the GBV campaigns through TV, with radio following at 20%.
- More than half of men (61%) heard about the campaigns through TV, with 24% hearing of them through radio and 12% from newspapers.
- "Act against abuse" is the best-known slogan among women (62%), while (77%) of men easily associate the slogan "Real men don't abuse" with GBV campaigns.
- Almost equal proportions of men (9%) and women (11%) link the slogan "Don't look away" with VAW campaigns, followed by "Peace begins at home".
- 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.
- The national curriculum for Grades R-12 has incorporated topics in its Life Skills curriculum that seek to address gender inequalities.
- GBV stories, and stories that mention GBV, constituted just 3% of all coverage in South African media, despite high levels of gender violence.
- The DOH, SAPS and NPA facilitated several trainings to capacitate personnel and other service providers to render services in a victim-friendly manner.



"I am Pulane, I grew up with my aunt, the woman who raised me. In 2009 she introduced me to my new parents who were her friends. They live here in Cape Town and they are white. They could not adopt me because I was over age but we decided it was fine for me to stay with them in Cape Town. It was okay living there sometimes, but there were a lot of bad things that happened. My new mom was in a wheelchair because her husband hit her with a metal steel stick on the back, which paralysed her.

The man was abusive and evil and sometimes he would just fight with her over nothing and hit her, even though she was in the wheelchair because of him. One day we ran away and stayed in a new house without him knowing. After eight months he found us through one of my mother's friends. He was well behaved for a few weeks but then he started his evil ways again. On January 7, he attacked me because I wanted to know why he was always shouting and making a noise. That was the most painful and horrifying day of my life. After that I came to the shelter and now I'm getting better because I love and believe in myself. I'm studying architecture and I'm happy and determined to do better for myself.

But when it comes to my personal life I am still hurting because my early life wasn't really good. When I was growing up it was just me and my aunt, but there was horror behind closed doors. My aunt is a very wealthy woman. She owns a bottle store and a club and has no children, so I was the only child. My real mom left me at my grandmother's gate when I was two weeks old. My grandmother raised me for two years, then she passed away in 1990 and my grandfather took over.

When I was eight years old the social workers took me to a home in Qwa-Qwa (Leratong Centre). I was there for one year and then I was told my aunt was coming to pick me up. She raised me well but after two years she started her weird behaviour. She used to sleep with her boyfriend in the same room with me, and she used to hit me with anything she could find. She wouldn't stop hitting me until she saw blood. Sometimes when I was sleeping she came into my bed, took off my panties and put her fingers in my vagina. It was weird and I was scared. I didn't know what to think and she continued abusing me. I had no choice but just do what she said.

Years later I grew up and she told me she was moving me to Cape Town to study and live with new parents and that's when another bad story started. But I thank God for surviving all these bad people. I am getting better every day."

After being rejected by her biological mother as a baby, Pulane moved from house to house and in all these houses she witnessed one or other form of abuse. As has been established in this report, witnessing abuse can have long term effects on the child and thus perpetuate abuse. This story underscores the need to work with communities towards building stable families and healthy environments for children. Prevention is key.

Given the cyclical and pervasive nature of GBV in South Africa, more emphasis needs to be put on preventative measures. To date most of the interventions have been responsive in nature. There are three main prevention levels, namely:

Primary prevention aims to address VAW before it occurs, in order to prevent initial perpetration or victimisation. Based on the fact that GBV has a lot to do with mindsets and attitudes, primary intervention is aimed at changing behaviour and attitudes, seeking to address the root causes of these attitudes at individual, relationship, community and societal levels. Inter-ventions can also aim to change risk-producing environments. Strategies include:

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

Secondary prevention happens immediately after the violence has occurred to deal with the short term consequences, for example treatment and coun-

selling. VAW survivors require comprehensive care and support from multiple service providers. This includes health, legal, social services, education, economic and social support. Secondary VAW interventions empower those charged with addressing VAW with the skills to promote prevention and the ability to deal sensitively with the topic. Strategies include training key stakeholders, including 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, e.g. perpetrator-counselling interventions.

This study focuses mainly on primary and secondary prevention initiatives in the Western Cape, as well as evaluates their impact within the South African GBV prevention model. Currently, most initiatives fall within secondary prevention. However, there is need for a paradigm shift to emphasise the importance of primary prevention.

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[111] identifies a number of "arenas" in which VAW is reinforced or can be challenged. This includes the individual, community, and society at large. It occurs within the context of the prevention, response 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); the broader society (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 and vice versa.
- ***Identifying approaches and strategies that work*** based on communication about 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 creating knowledge, wisdom and behaviour change. This in turn should lead to a quantifiable reduction in GBV.

Areas for action

The ecological model identifies key areas 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 find it very difficult to understand how a woman can be raped by a person she knows.

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

The ecological approach to gender-based violence argues that no one factor alone "causes" violence but rather that a number of factors interact to raise the likelihood that a particular man in a particular setting may act violently toward a woman. Similarly, various factors increase the likelihood of a particular woman in a particular setting becoming a victim of violence (Heise 2004).

Political will and commitment to address VAW

Political commitment by states, backed by action and resources, is crucial in the fight against GBV. During the State of the Nation address in February 2013, President Zuma expressed that "the brutality and cruelty meted out to defenceless women is unacceptable and has no place in our country". As such the government proposed to respond to the epidemic in the following way:

- Together with The International Medical Corps, which integrates strategies to combat violence against women and children, and NGOs that are actively involved in the fight against gender-based violence and women abuse, government will devise a strategy that will address most of the gaps and weaknesses in the current system.
- The new strategy aims to ensure effectiveness of the entire criminal justice system and target men and boys with a view to reorientating their psyche and mind set in respect of their female counterparts.

In most settings, political will is demonstrated through positive speeches and progressive policies and laws, without the actual backing up of resources. As such implementation is always lagging behind. Hence there is need to augment political commitment through the provision of services.

Policies

On 16 September 2013, the Western Cape Government launched the provincial Integrated Provincial Violence Prevention Policy Framework, which brings together a range of proposals focused on reducing and preventing violence in the Western Cape. The framework was developed in response to a long-standing need for a coherent and integrated framework for understanding and effectively tackling the very high injury and mortality rates resulting from interpersonal and other forms of violence in the Western Cape.[112] The policy emphasises three pillars for a violence prevention strategy:

- Reducing the availability and harmful use of alcohol.
- Creating a context for safe, stable and nurturing relationships between children and their parents and caregivers.
- Life skills development for at-risk children and adolescents.

Budgets

The government showed its commitment to addressing VAW by allocating a total amount of R16 million towards the VEP in the financial year 2013/2014. Table 8.1 shows the funds committed by the government through the DSD to cater for various developmental issues in the year 2011/2012.



Photo: Google Images

[112] http://www.westerncape.gov.za/news/western-cape-government-launches-violence-prevention-policy

Table 8.1 Transfer payments made by the DSD in 2011/2012			
Name of institution	**Amount transferred (ZAR)**	**Estimate Expenditure**	**Level of prevention**
Youth development	2 139 000	2 475 000	Primary and secondary
Institutional capacity building and support	1 100 000	1 100 000	
HIV and AIDS	8 682 000	9 197 000	Primary and secondary
Sustainable livelihood	20 833 000	19 238 000	Primary
Social relief	100 000	-	Primary and secondary
WSS: Professional & admin support	2 028 000	1 926	
Substance abuse, prevention and rehabilitation	35 062 000	35 012 000	Primary and secondary
Care and services to older persons	189 371 000	152 802 000	Primary
Crime prevention and support	6 624 000	6 945 000	Primary and secondary
Service to persons with disabilities	70 608 000	68 246 000	Primary
Child care and protection services	345 942 000	350 197 000	Primary
Victim empowerment	11 951 000	11 893 000	Secondary
Care and support services to families	33 400 000	33 109 000	Primary and secondary
Total	**727 840 000**	**690 215 926**	

Table 8.1 shows that the victim empowerment programme received a total amount of R11.9 million. This was geared towards assisting the victims of crime and the administration of restorative justice. It is noteworthy that child care and protection services received the largest amount of money (R346 million). This accounted for 47% of the total amount of money channelled towards transfer payments. Child care and protection services play a critical role in the prevention of GBV in the long run, and as such it is commendable that the DSD is allocating more towards the primary prevention of GBV. As was established, substance abuse is a significant driver of VAW especially in the Western Cape. The DSD allocated R35 million towards substance abuse prevention and rehabilitation. The institutions presented in the table above contribute either directly or indirectly towards GBV elimination and thus it can be said the government is making an effort to respond to the scourge. Despite the efforts by the government, the existing resources are disproportionate to the needs.

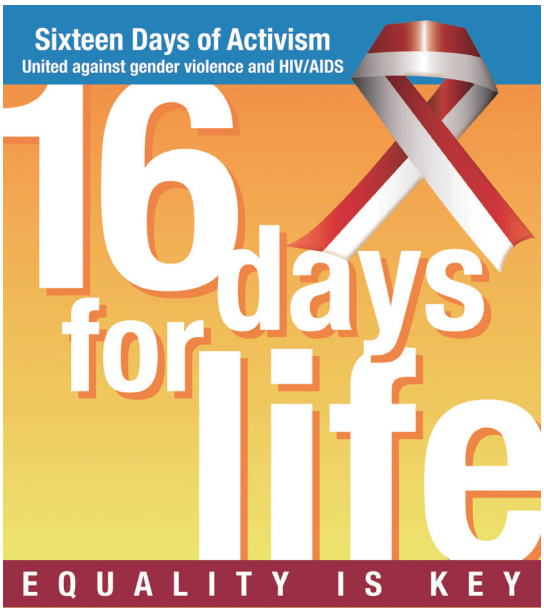
National public awareness campaigns: 16 Days of Activism against Gender Violence campaign

Each year, stakeholders hold several events to raise awareness about VAW 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.

Various government, civil-society organisations and the business sector come together annually to broaden the impact of the campaign. By supporting this campaign, thousands of South Africans help to increase awareness of abuse and build support for victims and survivors of abuse.



Case study: Western Cape government joins hands with CSO to eradicate GBV in the province



In the 2013 financial year, the Western Cape DSD transferred just over R15 million to NGOs in the victim empowerment sector to work with victims of violent crimes, an increase from R7 million in 2008/2009. This funding particularly benefited NGOs that render support services to rape victims in vulnerable communities, and is helping victims to recover from violence inflicted upon them, physically and psychologically.

Addressing root cause

The government is focusing on addressing the underlying causes of violent crime in the country. The 2008 National Youth Lifestyle Study by the Centre for Justice and Crime Prevention found that many young people are growing up witnessing violence and criminal activities in their communities, yet 74% of young people questioned in the study believed adults in their communities were setting a good example. In a 2009 study conducted by Professor Rachel Jewkes, head of the Women's Research Unit of South Africa's Medical Research Council, it was found that 62%of surveyed boys over age 11 said they believed that forcing someone to have sex was not an act of violence.

These findings speak to a growing culture wherein violence and abuse are seen as the norm. For this reason, the Western Cape government is working together with the NGO sector to promote the development of strong, resilient families, with a focus on the role of fathers, and to encourage men to take the lead in rejecting violence and abuse of women. They have made youth leadership development a priority in this regard, and their youth strategy speaks extensively to equipping young people with skills to reject violence and destructive behaviours. A series of programmes has been initiated that will provide young people with the necessary services, opportunities and support they need to deal effectively with the challenges of everyday life in South Africa.

Budget allocation

The government is also addressing the link between drug and alcohol abuse and violent crimes. Thus they have nearly doubled the budget for the reduction of drug and alcohol related harms over the past three years, from R42 million to over R77 million in 2013.

Response mechanisms set in place and building capacity of personnel

The need to speak out and break the silence has once again been highlighted. Rape and sexual crimes must be reported to the police. The government is encouraging victims to report these crimes, and to tell police about suspected rapists.

Every police precinct in the Western Cape has a victim support room (totalling 149 province-wide) where victims of rape can report crimes and give their statements in a safe and victim-friendly environment. Victim-support volunteers, who have been trained in a joint partnership between the Departments of Community Safety and Social Development and the SAPS will assist the victim through the police reporting process. Victims may, in most circumstances, take a family member or friend with them to give a statement in their home language.

Social workers are also available to provide counselling for rape victims and their families and can be contacted by visiting any local Social Development Office or by calling the Western Cape DSD's toll free line on 0800 220250. The Women Abuse Helpline is also available on 0800 150 150.

Rape, domestic violence and violence against women are not women's issues, they are everyone's issues. Women's safety ultimately affects everyone in society and communities must stand together to prevent sexual crimes and support victims.

The government is also seeking the reinstatement of the specialised sexual offences courts as these are vital to providing a deterrent to would-be rapists and send a clear message that rapists will be arrested and convicted if they commit this offence. While some individuals have distastefully capitalised on the death of Anene Booysen for political gain, the Western Cape government is committed to working with all stakeholders to tackle the scourge of violent crimes against women and children. *"We acknowledge that there is much work to be done and that it will take the active and committed participation of everybody if we are to make serious inroads into this problem."*

Adapted from Western Cape Government News, 2013[113]

Symbols and messages



Over the years since 1994, the government, spurred on by NGO efforts, has increasingly taken ownership of the campaign. The government symbol for the campaign is the beating of drums, to which it later added the strapline "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 "Sixteen 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 created their own variants of this theme and messaging. In 2004, NGOs chose to call the campaign "Sixteen Days of Peace" with the strapline "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 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 of the link between gender violence, 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 co-ordinated by the Department of Women, Children and People with Disabilities (DWCPD). Departments, provinces and civil society organisations use this framework as a tool to assist in determining focus areas.



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

[113] http://www.westerncape.gov.za/news/sexual-violence-everyones-concern

Case Study: Western Cape Network on Violence Against Women

The Western Cape Network on Violence Against Women (WCNOVAW) is championing the work on VAW prevention in the Western Cape. The case study below highlights the work of the Network in the fight against GBV:

Background

The WCNOVAW was established in 1989 as a direct response to an identified gap in co-ordination of activities by various organisations that work to end GBV. It is a member based network representing organisations that offer services such as shelter, support and life skills training to GBV survivors. Each affiliated organisation pays a membership fee to enable the smooth running of the network. The WCNOVAW has a secre-tariat responsible for co-ordinating the activities of the network. The secretariat is managed by two staff members. Currently the network has over 500 member organisations and individuals who work to promote gender justice in the Western Cape. These consist of counsellors, trainers, researchers, legal advocates, shelter workers, government officials, parliamentarians and concerned women and men from local through to international level. The WCNOVAW represents a sound integrated approach to transforming gender norms at a local level, as well as offering a comprehensive mechanism for the prevention of, and response to GBV.

Programmes

Through its member organisations, the WCNOVAW works with grassroots local structures in both rural and peri-urban areas. The WCNOVAW offers training for survivors of GBV as well as member organisations, depending on the needs of the member organisations as well as GBV survivors. The following are some of the training courses offered by WCNOVAW:

- Training in psychosocial support;
- Economic empowerment;
- Legislative procedures;
- Counselling;
- Human resources training for member organisations.

Apart from offering training, the WCNOVAW supports members with distribution of IEC materials, and helps to popularise activities of member organisations and individuals in the network. The WCNOVAW also actively participates in awareness raising campaigns like the 16 days of activism campaigns and other similar campaigns.

Western Cape Network on Violence Against Women

Advocacy issues

The WCNOVAW is currently lobbying for access to treatment for HIV positive women.

Success stories

As a result of years of conducting outreach and awareness campaigns, the WCNOVAW reports that there has been encouraging participation of women in the development of the DVA and the SOA.

Challenges

The WCNOVAW relies mainly on membership fees. Without adequate membership fees the network struggles to implement its strategies and this derails the commitment of members to giving much needed support to victims of GBV. In addition, the network is limited in capacity as the secretariat currently has only two staff members.

Mitigation

The WCNOVAW continues to engage key partners to undertake its programmes within member organisations and throughout the communities that it serves. To date, it has partnered with the SAPS, the SADC's Gender Unit, PCI as well as Thuthuzela Care Centres and other stakeholders.

Referral system

The WCNOVAW deals with a diversity of people from all walks of life. In response to GBV, it has a referral system to assist affected women and children. Most GBV reports which come through the network are assessed, then referred to an appropriate member organisation within the network which has capacity to assist. The WCNOVAW actively works with the SAPS and Thuthuzela Care Centres throughout the Western Cape for other referrals. It does not charge a fee for services offered to women survivors.

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 Organisations (CBOs), including those that target and involve men and boys for prevention and rehabilitation, faith-based organisations, traditional leaders and healers as well as the business sector, in crafting a co-ordination 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;
- The encouragement of community involvement in initiatives to combat crimes against women and children;
- The communication of government's substantive programmes and priority actions to deal with the problem of women and child abuse;
- The National Council Against GBV to be announced.

Awareness of and participation in national campaigns

Researchers asked women and men participating in the Western Cape survey about their knowledge and participation in VAW campaigns.

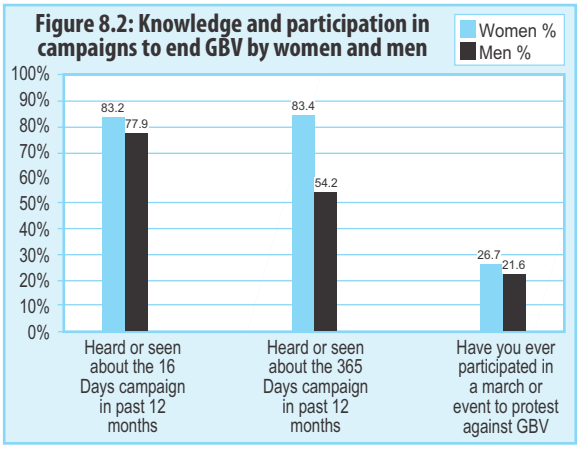


Figure 8.2 shows that women and men in Western Cape Province are relatively well aware of VAW campaigns. More women (83%) than men (78%) heard of the 16 Days of Activism. Again, a similar proportion of women (83%) and men (54%) knew of the 365 Days Campaign. Twenty six percent of women and 22% of men had participated in a march or event to protest against VAW. It is encouraging to note that for Western Cape, unlike other provinces, more women than men are aware of campaigns to prevent VAW. These findings indicate that almost equal numbers of women and men in the province have access to information about campaigns, and show greater willingness to participate in GBV events.

Source of information of events or VAW awareness campaigns

The survey asked participants further questions about where they had seen or heard about the campaigns.

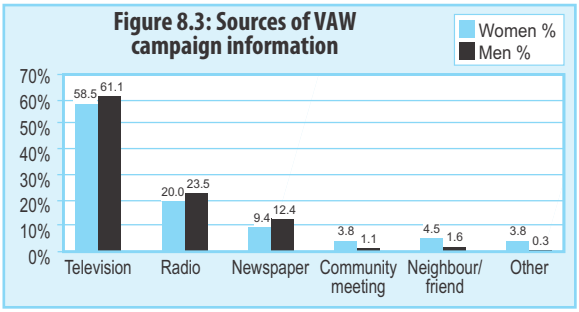


Figure 8.3 shows that the majority of women (59%) heard about the VAW campaigns through television followed by radio (20%), newspapers (9%), friends (5%), community meetings (4%) and other sources (4%). Men exhibited the same trend; more than half (61%) heard about the campaigns through television, while 24% learnt through radio, 12% through newspapers, 2% through friends, 1% through community meetings, and less than 1% from other sources.

This finding shows that stakeholders should publicise VAW campaigns primarily on television and radio to ensure maximum outreach impact in the Western Cape. However, there is also a need to accelerate efforts to disseminate this information at community meetings and in print media, especially if more men are to be reached.

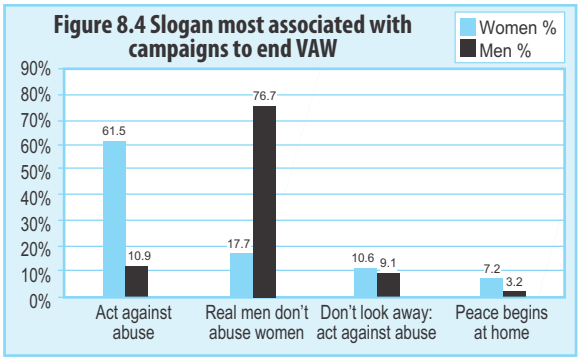


Figure 8.4 illustrates that "Act against Abuse" is the best-known slogan among women (62%). On the other hand, men easily associate the slogan "Real men don't Abuse Women" with VAW campaigns (77%). Almost equal proportions of men (9%) and women (11%) link the slogan "Don't Look Away" with VAW campaigns, followed by "Peace begins at Home" (7% women and 3% men).

Community mobilisation

Community mobilisation has proved to be an effective tool in addressing social issues such as VAW. It involves engaging community members and giving them platforms to own the project as they incorporate their ideas. Community mobilisation is a process which initiates a dialogue among members of the community, allowing them 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).

In as much as community mobilisation enhances social dialogue, the tool promotes social change by empowering community members and leaders to take responsibility for their own health through collective action. Community mobilisation empowers women to take charge of their lives as well as take action against VAW. It also offers a great opportunity to challenge men to disregard behaviours and attitudes that perpetuate the subordination of, and violence against, women.

Working with men

Engaging men in the fight against VAW has been informed by the philosophy that no man is born violent, rather they learn to become violent through the process of socialisation. As such, this underscores the importance of a positive socialisation were men are taught to be non-violent. 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.

Engaging them at an early age is vital in that boys learn that even though they may be physically different, girls are entitled to the same rights and opportunities as men. Gender roles and expectations in many societies condone male VAW, and grant young and adult men the power to initiate and dictate the terms of sex. This makes it very hard for women and girls to protect themselves from violence. Strategies to address both HIV and VAW 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.

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 ask, 'how can a man tell a woman's story?' (National Organisation for Men against Sexism, 2008).

It should be emphasised that men are an integral part of the drive to achieve gender equality. In regards to VAW, men as the main perpetrators of violence against women are part of the problem, but they can also be part of the solution. Thus engaging men is a relevant

and much needed part of the puzzle. Empowering women, coupled with engaging men to change their behaviour, can accelerate efforts to end VAW.

The Western Cape government has designed and is expected to implement programmes that seek to change the mindsets of abusers and potential abusers, in order to deal with the root causes of GBV and child abuse.

Case Study: Sonke Gender Justice Network



Sonke in Action against GBV. *Photo: Sonke Gender Justice Network*

Background

Formed in 2006, the Sonke Gender Justice Network works on human rights issues, focusing particularly on gender equality. Sonke notes that efforts to end violence against women need a holistic approach, and thus it works with women, men and boys to change masculinity norms and attitudes, in order to create a better society and one that respects humanity. Sonke seeks to enable men and boys to understand their role in the gender justice agenda. Sonke uses a variety of tools such as community workshops and mobilisation, media outreach campaigns (articles, newsletters, case studies, digital stories, short videos, films and photography), regional networking, political advocacy and strategic partnerships to transform masculinity norms in society, and also to achieve primary prevention of GBV at the household level.

Programmes

Sonke has four main programme units that are focused on achieving a gender just and healthy society. These are: Community Education and Mobilisation unit, Policy Development and Advocacy unit, Communications Unit, Sexual and Reproductive Unit, and Sonke's International Programmes Network unit.

Through its flagship tool, the One Man Can (OMC) campaign, Sonke has reached significant numbers of men and boys aged 15-30. This particular campaign aims to encourage the men to be active gender advocates with the aim of ending GBV and reducing the scourge of HIV and AIDS. The Brothers for Life campaign is directed towards older men (aged 30-50) and tries to safeguard their sexual and reproductive health. Men's involvement in

caregiving, maternal and child health, and non-violent parenting is all captured in the OMC campaign.

Sonke also conducts regular capacity building training with partner organisations, It works with prison inmates around issues pertaining to sexual violence and is currently challenging policy within the Correctional Services Department in order to initiate change in the overcrowding of the prisons, a situation which promotes sexual violence.

Achievements

Owing to its continued efforts to engage men and boys, Sonke has made inroads towards transforming traditionally gender biased societies and communities in the Western Cape. Sonke's OMC campaign continually produces short films for example the one titled; *A Way to Justice - Engaging Men for Women's Rights and Gender Transformation.* This and other short videos produced by Sonke inspire the men to take part in promoting gender equality.

> *"There has been a great response from men in the communities that Sonke works with and especially in traditionally labelled "no go areas" for gender activists".*
>
> Vuyiseka Policy Development and Advocacy - Sonke Gender Justice Network

A study commissioned by Sonke in 2012 shows an encouraging contribution by the churches to end GBV thorough spiritual teachings and they also gives encouragement and psychosocial support to survivors of GBV.

Challenges

Sonke notes that there is little follow-up by people when they report cases to the police, while on the other hand police do not adequately inform GBV survivors about how their cases are progressing in the investigation process. It is also a concern that the police tend to drag their feet in finding forensic evidence.

Sonke also notes that there is a huge backlog of GBV cases owing to incapacity of officials and also to administrative delays within the judicial process. Apart from these hindrances, Sonke is concerned about the lack of diversity in the judicial bench which is dominated by men.

Lack of political will is another hindrance that impinges on the gender justice agenda. Sonke envisages a situation where GBV is given the same urgency and elevation as what has been rendered to the HIV and AIDS pandemic.

Just like other organisations in this sector, Sonke has limited funding and this impedes effective and timeous implementation. The organisation also faces challenges in offering support to partner organisations which are doing a fantastic job in ending GBV.

Sonke has taken an active role in encouraging and assisting women judges, especially through the legal Advisors' Forum, to make nominations for the appointment of women in the High Court and the Constitutional Court.

Next steps

Sonke looks forward to working with the new Ministry of Women, Children and People with Disabilities, especially to highlight the challenges that women face and also to ensure that the National Strategic Plan is developed, implemented and monitored.

Education

The education system is also instrumental in primary prevention of GBV. Regular curricula, sexuality education, school counselling programmes and school health services can all convey the message that violence is wrong and can be prevented. They can also suggest alternative models of masculinity, teach conflict-resolution skills, and provide assistance to children/adolescents who may be victims or perpetrators of violence. Integrating VAW as a subject into psychology, sociology, medicine, nursing, law, women's studies, social work and other programmes enables providers to identify and tend to this problem.

Ministry of Education Life Skills curriculum

The National Curriculum Statement Grades R-12 has incorporated topics in its Life Skills curriculum that seek to address gender inequalities. The ministry has based the curriculum on various principles, including the principle of human rights as defined in the Constitution of the Republic of South Africa.

Table 8.2: Content of the Life Skills programme upholding gender equality

Topic	*Grade 4*	*Grade 5*	*Grade 6*
Social responsibility	• Children's rights and responsibilities; • Cultures and moral lessons; • Knowledge of major religions in South Africa: Judaism, Christianity, Islam, Hinduism, Buddhism, Baha'i Faith and African religions.	• Concepts: discrimination, stereotype and bias; • Child abuse; • Dealing with violent situations; • Issues of age and gender; • Festivals and customs of a variety of religions in South Africa.	• The dignity of the person in a variety of religions in South Africa; • Cultural rites of passage; • Caring for animals; • Caring for people; • Nation-building and cultural heritage; • Gender stereotyping, sexism and abuse.

Source: Life Skills Report, Department of Basic Education, 2011.

Case study: The City of Cape Town and the WCG join forces to improve school safety

The City of Cape Town and the WCG are committed to working together to create secure environments in which teaching and learning can take place without fear or disruption. In line with this commitment, they are launching a pilot project that will see School Resource Officers (SRO) being introduced to a selection of schools within the Cape Town metropole. A SRO is a sworn Metro Police officer assigned to a school on a long-term basis.



Western Cape Banner *Photo: Ntombi Mbadlanyana*

Funded by the City of Cape Town and aligned to the programmes of the Western Cape Education Department (WCED) and the Department of Community Safety, the SRO Pilot Project aims to build safer school environments and safer communities by having a dedicated person to co-ordinate and improve on existing school safety initiatives.

By forging effective partnerships between participating schools and the communities in which they operate, the SRO Pilot Project aims to supplement existing school safety programmes. Each SRO will be responsible for working with the principal, school safety committee, learner support staff, school safety volunteers, departmental officials and all other role-players at or assigned to their school to identify and address the underlying problems which may lead to disorder, ill-discipline and crime, and implement strategies to overcome these problems to make schools and their immediate surroundings safer.

They will work with appropriately qualified and skilled Metro Police officers who are equipped to provide the following support to participating schools, as well as their staff, learners, parent groups and the communities in which they operate:

- Providing law enforcement services to participating schools and areas adjacent to these schools;
- Providing relevant advice and support to school staff, school safety committees, school safety fieldworkers and school district coordinators;
- Developing and implementing school-based crime prevention programmes and programmes that promote good behaviour and social cohesion within the school environment;
- Improving the readiness of schools to deal with emergency situations;
- Assisting schools with the early identification of illegal activities involving youth at risk;
- Creating networking opportunities that promote community involvement in school safety initiatives; and
- Providing supervised after-school activities for learners on school and community safety-related topics.

With this initiative, the WCG and the City of Cape Town hope to build a positive relationship between the Metro Police and the youth in the Cape Town so that school-related violence and crime can be reduced and prevented. To give effect to this initiative, the Safety and Security Directorate of the City of Cape Town and the WCED have entered into a memorandum of understanding to define their respective roles in the SRO Pilot Project. The project has been aligned to the strategy of the WCED's Safe Schools Programme which focuses on:

- Crime control by modifying and enhancing school environments;
- Crime prevention by changing the attitudes and behaviour of learners and school staff;
- Systems programmes by developing effective partnerships between schools, the communities in which they operate and other role-players.

The SRO Pilot Project has also been developed in consultation with the Department of Community Safety (DCS) to ensure that synergies are created and maximised between participating schools, the WCED, the SROs and school safety volunteers provided by the DCS. The following schools will participate in the first phase of the SRO Pilot Project:

- Chrystal High School (Hanover Park)
- Phoenix High School (Manenberg)
- Bishop Lavis High School (Bishop Lavis)
- Lotus High School (Lotus River)
- Sizimisele High School (Khayelitsha)
- Oscar Mpetha High School (Nyanga)

The City of Cape Town will be responsible for the day-to-day operation and management of the SRO Pilot Project, as well as the conduct of SROs they employ. School principals and their management teams will remain responsible for the operation and management of their schools but will have oversight over the SROs in all matters relating to learner and staff safety. The City of Cape Town and the WCED's Safe Schools division will meet on a monthly basis for the duration of the SRO Pilot Project, to monitor the implementation of the project and to ensure that this initiative has the best chance possible of succeeding.

Adapted from South African Government Website[114]

Academia has also joined forces with other activists to speak against GBV in South Africa. Unisa principal and Vice-Chancellor Prof Mandla Makhanya is reported to have felt absolute disdain and contempt for the scourge of rape and harassment to which the women and children of South Africa are exposed. He said South Africans surely cannot be proud when the rest of the world views us only through this lens because this is what they are reading about in the news. Addressing Unisa staff he was quoted saying: "The latest very cruel and deplorable case of a young 17-year-old girl who was raped and murdered in

[114] http://govza.gcis.gov.za/node/484497 accessed 25-07-2014

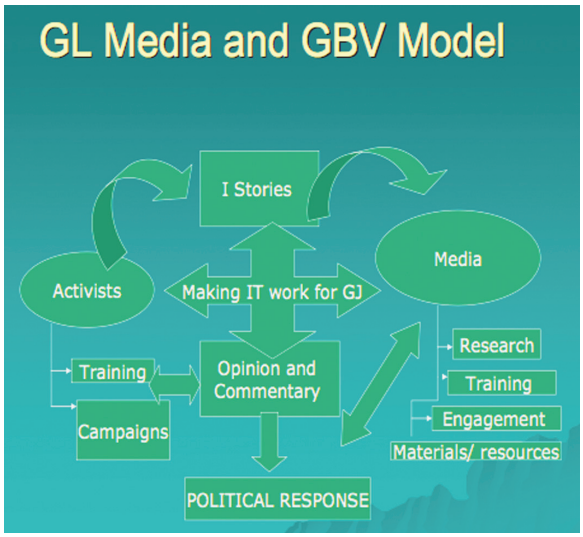
Bredasdorp enticed me to emphasise to all of you that we need to take a stand against this unacceptable behaviour. We all need to pause and consciously reflect on the values of respect for life, and the dignity of each fellow human. We are all part of civil society and rape and violence affects every one of us, no one is exempt. We cannot sit back and wait for others to set the foundation for change - that role belongs to all of us."[115]

VAW and the media

The media plays an important role in the fight against GBV. The media can either be part of the problem or part of the solution in fighting VAW. The media is a potentially powerful tool because it not only reports on society but helps shape public opinion and perceptions. It is a key conduit for making VAW visible, advertising solutions, informing policy-makers and educating the public about legal rights and how to recognise and address VAW.

Gender Links' GBV and media model is illustrated in the diagram. The key elements of GL's media strategy are as follows:

- Working directly with mainstream media through research, training, developing gender policies, continual engagement, and providing useful links, contacts etc.;



- Working with gender activists to develop strategic communication skills and package their issues more effectively to ensure media coverage;
- Providing bridging services between activists and the mainstream media through the GL Opinion and Commentary Service, especially working with survivors of gender violence to tell their stories and providing content that is often difficult for the media to access due to lack of trust, time and skills constraints;
- Using IT to maximise impact, build skills and capacity.

Coverage of VAW in South Africa

Over the last decade, GL has conducted training workshops with media in all nine provinces of South Africa as well as media monitoring. Key findings of this monitoring include:

- To the extent media covers gender issues, gender violence tends to get more coverage;
- However, gender violence is often treated as relatively minor compared to other crimes;
- Certain types of gender violence get much higher coverage, e.g. sexual assault;
- There is very little coverage of where those affected can get help;
- There is very little coverage of those who protest against gender violence;
- Much of the source information is from the courts. This has a heavy male bias;
- The media doesn't report the voices of those affected;
- The media often trivialises the experiences of women;
- There is a tendency to exonerate the perpetrators;

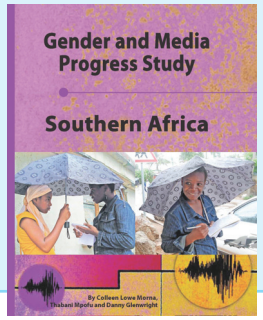
[115] http://www.unisa.ac.za/news/index.php/2013/02/south-africa-the-worlds-rape-capital/

- Coverage is often insensitive, e.g. in the use of images, names etc., which could lead to secondary victimisation;
- The media often portrays women as victims rather than survivors;
- There is a tendency to sensationalise;
- The media often portrays women as temptresses (they asked for the abuse);
- The media often portrays men as being unable to control their sexual urges; and
- Men or court reporters write most gender violence stories.

In the 2010 Gender and Media Progress Study, GL monitored media in 14 Southern African countries including South Africa. In addition to monitoring general media practice and content, GL looked at coverage of HIV and AIDS and GBV. For GBV, monitoring focused on the proportion of VAW coverage, VAW sub topics, who speaks on them, their function, and who reports on these topics. The monitoring period ran from 18 October to 18 November 2009.

Key findings of the 2010 GMPS include:

- VAW stories and stories that mention VAW constituted just 3% of all coverage in South African media, despite high levels of gender violence.
- Rape receives the most coverage in South African media (24%) followed by child abuse (18%) and domestic violence (12%). Non-physical abuse (8%), men killed in abusive situations (8%) and femicide (7%) receive the highest proportion of coverage after rape, child abuse and domestic violence. Coverage of relevant policy and legislation is very low in South Africa (6%). Stories on support to people affected by gender violence and sexual harassment are largely absent in media coverage in both South Africa and the region.



- Men dominate as news sources in stories about VAW. Women comprise just 24% of the sources in these stories despite the fact that women are most affected.
- The voices of police and judges, the legal system and experts dominate in VAW coverage in South Africa (39%).
- Survivors constitute 15% of sources on gender violence while alleged perpetrators or perpetrators constitute 10% of sources in VAW stories. Relatives of victims or perpetrators speak on gender violence in 13% of articles. These figures underscore a common concern that people too often speak on behalf of victims and survivors of VAW.

Secondary prevention

Secondary prevention takes place immediately after the violent event occurs and includes steps which decrease the likelihood of the event recurring.

Health personnel training

Medical practitioners need to be capacitated and trained in all forms of gender violence and their subsequent possible health consequences. As highlighted in Chapter 3, health personnel need to be capacitated in GBV screening, which can aid in reducing recurring acts of GBV. Currently, 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.

DOJ & CD personnel training

Court personnel are trained in issues pertaining to sexual offences and domestic violence. All in all, 461

sexual offences and 227 domestic violence trainings were conducted nationally (DOJ & CD annual report, 2011-2012).

Development of materials by the DOJ&CD

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

Training in SOA-related issues by the DOJ&CD

In the 2011-2012 financial year, the NPA's SOCA conducted multi-disciplinary training in the investigation and prosecution of sexual offence cases. The training courses included advanced skills in prosecuting the child sex offender, child pornography training seminars and integrated training for case managers, victim assistance officers, site co-ordinators and relevant stakeholders involved in TCCs and SOCs.The department also developed the training manual on criminal law (sexual offences and related matters), and conducted 23 training sessions for 645 prosecutors in all provinces.

Training in DVA-related issues by the DOJ&CD

From 2011 to 2012, the SOCA team delivered five training sessions covering the DVA, attended by 108 prosecutors.[116] The SOCA also established a 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 related to protection orders, but also those offences linked to GBV.

The DOJ&CD's Justice College has dedicated training programmes for clerks and prosecutors. The SA Judicial Education Institute is training the judiciary in matters relating to Domestic Violence. The DOJ&CD, in partnership with NPA, also offers training in the Family Law Practice: SAQA Qualification No. 50265, which carries three unit standards covering domestic violence, equalling a total 32 credits. In 2011 and 2012 the Justice College conducted training programmes for court officials.

Table 8.3: Training of DV clerks

Financial Year	Participants	Domestic Violence Act: Justice College
2010 - 2011	DV Clerks	142
1 April 2011 to 31 January 2012	DV Clerks	205
TOTAL		347

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

The NPA also conducts multi-disciplinary training through the Integrated Domestic Violence training programme. The programme covers all the roles of stakeholders within the DV sector. Forty five delegates including doctors, advocates and investigators attended the technical assistance training programme in March 2011 in Maputo.[117]

Training traditional leaders

Traditional leaders wield influence and command much respect within their communities. Traditional leaders as custodians of culture occupy a strong position in terms of working with their communities to address the harmful cultural practices that trigger and perpetuate VAW. In South Africa they preside over

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

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.[118]



President Jacob Zuma and traditional leaders. *Photo: Google Images*

Project Ndabezitha

The Ndabezitha Izimbizo Project seeks to engage rural communities on issues of domestic violence. Along with the NPA, the project trains traditional leaders and court clerks in domestic violence matters in rural areas.

At the Justice, Crime Prevention and Security (JCPS) Cluster media briefing in Parliament on 4 March 2010, Jeff Radebe, Minister of Justice and Constitutional Development, emphasised government's commitment to fostering partnerships with the community and deterring crime in general. He said the cluster's specific focus in fighting crimes against women and children was on strengthening awareness programmes in communities. This included the development of a safety tool, and inter-sectoral statistical tool, by the NPA and the DOJ&CD.

Training of the SAPS

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

During 2011-2012, the SAPS participated in a regional training workshop with the United Nations Office on the Drugs and Crime (UNODC) as co-ordinators, to develop training programmes in effective law enforcement, responses to violence against women - particularly domestic violence - in the Southern African region. It also presented the Violence against Women and Children course to the Southern African Regional Police Chiefs Co-operation (SARPCCO) task team at a work session in Pretoria. This was part of the SAPS and South African government's commitment to assist the SADC in addressing GBV within the region.

SAPS staff training on Domestic violence Act and Sexual Offences Act

Bearing in mind that issues relating to GBV, especially violence against women and children, are sensitive issues, the SAPS has taken measures to ensure that adequate and properly trained personnel are available to deal with issues of violence against women and children. The SAPS have trained female officers who are more likely to relate to the survivors, who are mostly women.

Conclusion

This chapter outlined the primary and secondary preventive measures that have been put in place to end GBV, illustrating that no single mechanism can be used to tackle the multi-faceted nature of VAW. As such, addressing the root causes of violence at individual, relationship, community and society levels is critical in changing behaviour and attitudes.

[118] http://www.popcouncil.org/projects/301_TradLeadSGBVSouthAf.asp

Some of the strategies highlighted in this chapter include political will and commitment to addressing VAW. This is often demonstrated through positive speeches and progressive policies, however this needs strong back-up with adequate funds and resources. Awareness raising campaigns play an integral role in the drive to combating VAW. Reports show that more women than men are aware of such campaigns, implying that women in the Western Cape are generally aware of the mechanisms in place to alleviate their situation.

Also highlighted is a more proactive prevention strategy focused on working with men in fighting GBV. It is encouraging to note that the WCP is actively engaging men and boys through the work of civil society and through training by the DSD. Such strategies are important as they are aimed at bringing lasting changes to attitudes and practises that perpetuate male dominance.

It is critical to have state structures that are responsive to the needs of women. To this end, the training of the SAPS and of prosecutors by the DOJ&CD to deal with issues of violence is highly commendable. Challenging traditional customs preserved in rural areas has also been shown to play an important role in preventing GBV. The training of traditional leaders, who wield influence and command in the communities they serve, on GBV issues is therefore critical.

The Ministry of Education's Life Skills Programme incorporates topics in its curriculum that seek to address gender inequalities. This is instrumental in stopping violence against women in the early stages of life.

A number of case studies has also been presented in the chapter and these have shown interplay between the preventive and responsive strategies. Going forward, it is imperative for governments to allocate more resources to primary prevention efforts but also sustain secondary and tertiary interventions to end GBV.



CHAPTER 9
INTEGRATED APPROACHES



Centres of Excellence Implementation Workshop. *Photo: Ntombi Mbadlanyana*

Key facts

- The existing 365 Day National Action Plan to End Gender Violence falls short of proper implementation.
- South Africa has a National GBV Council with a mandate to provide strategic guidance and to monitor the implementation of all programmes dealing with the elimination of GBV in the country.
- The JCPS Cluster is mandated to ensure public safety including protection against VAW.
- The Cluster has a Domestic Violence task team to draft, implement and monitor the integrated domestic violence strategy, committees on sexual violence and a victim empowerment forum.
- Western Cape has four Thuthuzela Care Centres in operation.
- Since its inception, the VEP has faced various challenges, including the absence of effective monitoring and evaluation mechanisms and inadequate facilities for victims of crime. The most striking is the shortage of shelters to house victims of VAW in the rural areas.
- The WCG and DOH have adopted the "whole-of-society" approach, aimed at tackling the root causes of violence.



"My name is Khethiwe. My abuse started in 1978/1979. I was living with my aunt who was my mother's cousin in Port Elizabeth. I started staying with her because my mom was working and not able to look after me. Very often I would end up doing house chores and looking after her children.

One day I burnt myself with boiling water while cooking. The water fell on my thighs inside the corduroy pants I was wearing. I sat the whole week wearing the same wet pants until Friday, then my other aunty, * Gladys, arrived at the house and found me smelling bad. She took me and gave me a bath and washed the sore. Aunty Gladys then took me to live with her.

Then I went to live with auntie Gladys, and it was better living with her, but then she decided to take me to go and live with my father's family. I did not know why she did that to me. By the time I arrived at my father's family I was almost seven years old. I lived with my grandparents, uncle Sipho, and cousins. My father's family were relatively well off and well-respected church leaders. They also had a good reputation in the community.

Then things started going bad when I was in Standard two. I was around 10 years old, and my uncle Sipho started sexually abusing me. He would follow me to the kitchen, and when I washed the dishes he would start fondling me and sexually touching me, and told me to keep quiet. This was the start of the abuse, then he left to return to University as he was still a student at the time studying in Cape Town. I told my grandparents about the abuse that I had been experiencing during that holiday.

My grandparents never believed me when I told them about the abuse. They said I was lying and that I enjoyed what my uncle had done to me, otherwise why I was reporting the matter after he had gone already. Every time he would return home for the holidays, he would continue to abuse me sexually, until I decided to run away from home to go to Johannesburg with a friend. I was 14 years old at the time.

When I got to Johannesburg I stayed with my friend in Hillbrow. She told me I had to hustle and make a plan to live in the city. I did not have a job and had nothing in my name, until my friend told me to start being a prostitute. I began being a prostitute in Hillbrow from the age of 15.

I met *Thomas, who fell in love with me. I moved in with him and we lived together for two years and had a son. Unfortunately, Thomas was shot in a taxi related gang incident and he died. The baby was six weeks old, and I was staying with his family. I raised my son in Johannesburg, I got a job, all was well, and I met the father of my second child. We had my daughter and everything seemed well. I then also discovered I was HIV positive. My little boy was also HIV positive. He survived until he was five, then passed away due to complications and no treatment for his sickness. I continued living in Johannesburg until and then my little daughter and I relocated to the Eastern Cape. I met another man after my second partner was abusive towards me and I left him.

We lived with his family when we got to the Eastern Cape and he treated me well in the beginning. All seemed to be going well but then the abuse started and he was violent. I ended up leaving him and going back to Cape Town. In 2007, I met Alma Kritzinger at Mossel Bay municipality and my life changed. I started attending Victim Empowerment Training. I am now a trained peer counsellor who provides counselling for people living with HIV/AIDS and I treat those with issues of loss and grief.

My life journey has been about helping people who are victims of abuse. I tell them my life story and what I have experienced. I also share my status and motivate people to live in a good way to motivate other people."

This chapter focuses on integrated approaches rolled out in South Africa in an effort to respond to GBV. The South African government's National Development Plan vision for 2030 emphasises building safer

communities through an integrated approach. One of the outcomes identified in the Medium Term Strategic Framework (2009-2014) is to ensure that "All people in South Africa are, and feel safe."[119]

VAW is such a complex problem that its solution requires strategic and inter-sectorally co-ordinated policies and actions, with the participation of both the state and civil society. In this context, the health, regulatory (legal enforcement), education, and non-governmental sectors are fundamentally important. Each of these sectors has a critical role to play in detecting, recording, addressing, and preventing domestic violence. In real terms, however, the responses of these sectors as service providers are inadequate and insufficient in the majority of cases, given the perceptions and opinions that exist in regard to VAW. In May 2006, stakeholders organised a conference with government and civil society at Kopanong. The conference led to two outcome documents - the Kopanong Declaration and the National Action Plan to End Gender Violence (NAP). The aim was to devise strategically co-ordinated policies and actions, augmented by the participation of both the government and civil society.

The 365 Day National Action Plan to End Gender Violence

The Kopanong Declaration acknowledged that the 16 Days of Activism against Gender-based Violence campaign is not sufficient to address VAW 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).[120]

The plan is anchored on the recognition that no single sector, government ministry, department or civil society organisation is on its own 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 use the NAP as the basis on which to develop their own strategic and operational plans to ensure unity of purpose and cohesion of efforts, which will in turn achieve maximum impact in eradicating VAW.[121]

Evaluation of the 365 Day National Action Plan

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

It was found that since the official launch, proper implementation of the plan was non-existent. A major impediment is the lack 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.

The National Council against GBV



Minister of Women Children and People with Disabilities, Lulu Xingwana, and Gauteng Premier Nomvula Mokonyane launch a gender project in Pretoria. *Photo: Colleen Lowe Morna*

[119] http://countryoffice.unfpa.org/southafrica/drive/FinalTORNSPonGBV09July2013.pdf
[120] http://www.unicef.org/southafrica/SAF_resources_365daysdeclaration.pdf
[121] http://www.unicef.org/southafrica/SAF_resources_365daysdeclaration.pdf
[122] http://www.services.gov.za/services/content/news/GenderBasedViolence/en_ZA

Deputy President Kgalema Motlanthe launched the National Council Against GBV (NCGBV) on 10 December, 2012, in Rustenburg.[122] Motlanthe chairs the council, which is championed by Minister of Women, Children and People with Disabilities, Lulu Xingwana.

The NCGBV 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 leaders, members of the women's movement, academic and research institutions and government across all spheres and the South African Local Government Association.

The NCGBV 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 Day NAP and advise government on policy and intervention programmes;
- To strengthen national partnerships in the fight against GBV;
- To create and strengthen international partnerships on GBV;
- To monitor and report progress on initiatives aimed at addressing GBV.

The work of the NCGBV pertaining to the 365 Days NAP is anchored on five pillars:

1. **Communication and co-ordination pillar**
   The development of a national communication strategy aimed at changing behaviours is underway. The council will hold consultations with relevant stakeholders to strengthen provincial, national and international partnerships and alliances. It will also facilitate and co-ordinate all stakeholders for partnership around national events, interventions and mobilisation for indicated action. In addition, the council will strengthen and facilitate inter-departmental collaborations. It also plans to hold consultations and mobilise resources. In addition, the council will work with relevant stakeholders to review and distribute service directories on GBV as well as organise road shows on GBV.

2. **Prevention pillar**
   Activities lined up under this pillar include education and awareness programmes and organising inter-generational dialogues. The council will also organise and co-ordinate inter-sectoral seminars, workshops and conferences as well as popularise the victim support programmes, policies and legislation. In addition, the prevention strategy will include strengthening campaigns against alcohol, substance abuse, Satanism, multi-killings and witch killings.

3. **Research and information pillar**
   This pillar is as important as the previous two. It involves auditing research conducted on GBV as well as mapping hotspot areas and NGOs operating in these areas. This will also include researching the efficacy of interventions for offenders and victims in order to make recommendations on upscaling and strengthening them.

4. **Support pillar**
   Under this pillar the council will conduct an audit of safe house programmes while facilitating the enhancement and promotion of individual/family-based support services and access to multi-sectoral services. The council will also monitor the implementation of victim empowerment initiatives, and strengthen accountability of public and private sector entities through effective monitoring. Another responsibility

[122] http://www.services.gov.za/services/content/news/GenderBasedViolence/en_ZA

pertaining to support is to address the discrepancies between rural and urban areas.

5. **Response pillar**
   Here, the council is mandated to monitor and evaluate the response of the public and private institutions to GBV and to facilitate the roll-out of green/white doors (support services) to other provinces. In addition, the council will strengthen the multi-sectoral rapid response programme to facilitate immediate access to services.

6. **Monitoring and evaluation and policy pillar**
   The council's role here is to facilitate the popularisation of legislation dealing with VAW. It is also to facilitate the review of legislation and policies dealing with GBV, in particular the DVA and the parole laws, and then make policy recommendations.

Adapted from the presentation by Minister Lulu Xingwana: The National Council on Gender-Based Violence and its Priority Programmes, April 2013

Progress in the development of the National Strategic Plan to end GBV

The NCGBV is championing the development of the National Strategic Plan (NSP) to end GBV which is scheduled to be completed by the end of 2014. The plan is being developed by the Human Science Research Council in consultation with the NCGBV technical team. The team comprises both government departments and members of CSOs.

Justice, Crime Prevention and Security

The Justice, Crime Prevention and Security (JCPS) cluster is mandated to achieve Outcome 3 of the NDP, namely that all people within South Africa are and feel safe, and has thus put in place various governance structures aimed at addressing the issue of public safety including VAW. The structures include:

Table 9.1: Structures in place to ensure public safety

Structure	Chair
JCPS domestic violence task team CD	DOJ&CD
Inter-sectoral Steering Committee on Sexual Offences	DOJ&CD
Inter-departmental management team on Sexual Offences	NPA
Victim Empowerment Management Forum	DSD

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

The JCPS cluster has adopted an integrated and co-ordinated, holistic approach in the fight against crime, and seeks to continue to improve prevention, detection, investigation and prosecution through integrated policies and frameworks, and increased capacity.

- Various Protocols have received attention in terms of the implementation of the Criminal Justice System's 'Seven-Point-Plan' to ensure the effectiveness of the justice system. These include a Court Screening Protocol and a Legal Aid Court Protocol to improve co-ordination of work between the NPA and legal aid representatives. Court Screening has been developed to ensure case readiness and improve case scheduling.
- The Policy Framework (NPF) for the Accreditation of Diversion Services in SA was finalised in May 2010. This policy framework supports the Child Justice Act which was implemented in April 2010, while a draft Sexual Offences NPF has also been developed to improve and co-ordinate the criminal justice system's responses to sexual offending. It aims to improve how cases are being dealt with at court level, and regulate the manner in which sexual offences and related matters are dealt with, namely in a co-ordinated and sensitive manner, with the emphasis on a multi-disciplinary approach.
- The JCPS cluster also focuses on creating awareness, especially in rural communities around issues relating to crimes committed under the guise of customary practices. The cluster makes it clear that it will not tolerate any criminal act of kidnapping

and rape inflicted on young and defenceless girls, disguised as the cultural practice of Ukuthwala.[123] As such the JCPS cluster will continue to work with traditional leaders in this regard.
- The JCPS cluster also prioritises crimes against women and children and provides support through Thuthuzela Care Centres.[124]

Department of Justice and Constitutional Development

After having noted the lack of a co-ordinated strategy between JCPS cluster departments in implementing and monitoring the DVA, the JCPS Domestic Violence task team was established, to draft, implement and monitor the integrated domestic violence strategy. The DOJ&CD is mandated by the JCPS to chair this task team, which consists of the DOJ&CD, NPA, Legal Aid SA, SAPS, DSD, DOH and the judiciary. The Departments of Women, Children and People with Disabilities,, Transport and Housing, as well as Co-operative Governance and Traditional Affairs (National House of Traditional Leaders), play ancillary roles.

In summary the DOJ&CD initiatives include:
- Development of JCPS domestic violence strategy to improve the co-ordination of services (the draft strategy is in the process of submission and approval by the JCPS cluster Directors-General);
- Development of violence prevention strategy;
- Capacitating courts, especially large courts such as Johannesburg Family Court;
- Development of Braille awareness-raising material;
- Specialised training with Justice College and the NPA at Domestic Violence sections.[125]

Western Cape Government

The WCG has adopted the 'whole-of-society' approach to drive its Provincial Strategic Objective number five, which seeks to increase public safety. The same approach has been used in the violence prevention strategy. The 'whole-of-society' approach focuses on the root causes of violence and the situational contexts of violence as the main response to violence. This approach dovetails neatly with the proactive, preventative public health approach. Both approaches emphasise the importance of evidence-based interventions. The successful implementation of this policy will require the co-operation of all role-players in the public health and criminal justice sectors, as well as the active participation and partnership of citizens and civil society more broadly.

The Thuthuzela Care Centres

The NPA's Sexual Offences and Community Affairs (SOCA) unit is mandated to manage the Thuthuzela Care Centres (TCCs), introduced as part of South Africa's national anti-rape strategy. 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 with the aim of:
- Reducing secondary trauma for the victim;
- Improving conviction rates;
- Reducing the cycle time for finalising court cases.

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.[126]

Located in public hospitals, the hospital-based model aims to provide survivors with a broad range of essential services - from emergency medical care to

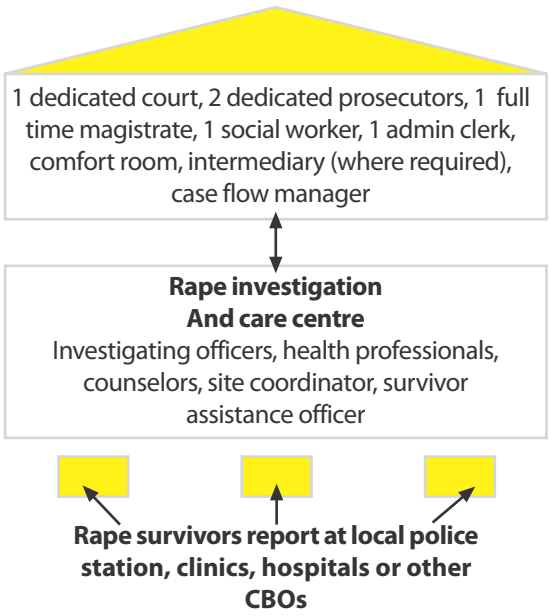
[123] Ukuthwala is a form of abduction that involves kidnapping a girl or a young woman by a man and his friends or peers with the intention of compelling the girl or young woman's family to endorse marriage negotiations.
[124] Department of Justice and Constitutional Development 20 Feb 2011.
[125] http://www.pmg.org.za/print/report/20120215-department-justice-constitutional-development-implementation-domestic
[126] NPA, 2010 www.npa.gov.za

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.

Figure 9.1: Thuthuzela Care Centre model

Sexual Offences Court
- Prosecution of SO cases
- Weekly strategy meetings and case assessments
- Consults with survivors throughout court process
- Ensures speedier, more effective prosecutions

Objectives
- Reduce secondary victimisation
- Improve conviction rate
- Reduce the time to finalise 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
- Offers immediate crisis counselling for survivors

TCCs operate best in public hospitals close to communities where the incidence of rape is particularly high. They are also linked to SOCs, which are staffed by skilled prosecutors, social workers, magistrates, NGO representatives and police. 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 had 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.

Source: NPA Annual report 2011/2012.

Table 9.2: Number of TCCs in Western Cape

Province	Total sexual offences reported to police 2011/12)	Number of TCCs	Name of TCCs	Name of hospital	Location: rural/urban
Western Cape	9 133	4	Mannenberg TCC	GF Jooste	Urban
			Belville TCC	Karl Bremmer	Urban
			George TCC	George	Urban
			Worcester TCC (being established)	Worcester	Rural
			Potchefstroom TCC (being established)	Potchefstroom	Rural

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

Table 9.2 shows that the total number of TCCs in WCP was not enough to cater for all the sexual offences reported to the police in the year 2011/12. The establishment of more TCCs nationwide is a clear indication that the extent of sexual violence is being acknowledged and acted upon by government and other stakeholders.

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 9.3: Change in number of cases reported at TCCs (nationally) between 2010-11 and 2011-12

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

Source: (NPA Annual report 2011/2012).

Table 9.3 shows an increase in the number of reported cases and an improvement in case management from the 2010-11 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 all these cases 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 before cases come to completion, and to the huge court backlogs. There are also insufficient magistrates or court officials to deal with the influx of sexual offences cases.

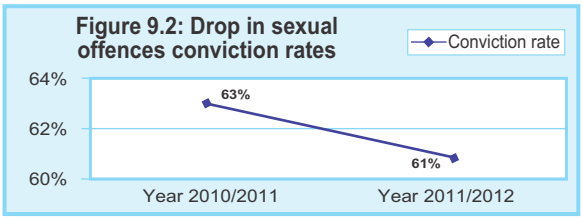


Figure 9.2 shows the average conviction rate of sexual offences prosecuted at sites linked to TCCs dropped from 63% to 61% between the two financial years. According to the 2012 DOJ&CD annual report, this drop can be attributed to various factors including, a substantial drop in the number of dedicated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

The Integrated Victim Empowerment Policy

The Integrated Victim Empowerment Policy (IVEP) forms part of the strategic efforts of the government to prevent crime and to create a peaceful crime-free country. The IVEP recognises the importance of all stakeholders, both in the public and private spheres, who deliver services to victims. The policy therefore provides for the co-ordination 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;
- Create a common understanding of victim empowerment amongst various state departments, victims, perpetrators, NGOs, CBOs and individual members of the community (IVEP Draft 2007).

Intervention strategies

The guiding principles for the IVEP are embodied in values that determine the nature of services for victims, respecting the rights of the victims and applying the principles of "*Ubuntu*" (human kindness) and "*Batho Pele*" (putting others first). The IVEP has core intervention strategies based on the concept of a victim-centred approach which avoids secondary victimisation. These strategies apply to all sectors involved in the empowerment of victims.

Integrated Provincial Violence Prevention Policy Framework

The Integrated Provincial Violence Prevention Policy Framework (IPVPPF), launched in September 2013, focuses on the key strategies to be adopted in preventing violence in the Western Cape. It recommends the adoption of a comprehensive inter-sectoral approach that balances short-term evidence-based interventions, focused on reducing the availability and harmful use of alcohol, with longer-term interventions that require the state and all citizens to take active responsibility in addressing the complex social norms that support violence more holistically.

The policy framework is intended to bring coherence and clarity to the government's objectives in the field of violence prevention across sectors. Historically, society has relied in large part on the criminal justice system or 'law enforcement' approach to violence, in which institutions of criminal justice, the police and prisons are the main response mechanisms to violence. Unlike the traditional law enforcement approach to violence, the public health approach used by the IPVPPF focuses on how underlying causes and risk factors - operating at the level of society, community, family and the individual - interact to produce acts of violence. It draws on the resources, capabilities and the collective ability of every single citizen - working in partnership with one another and the state - to demotivate potentially violent offenders and remove the opportunities for them to engage in acts of violence.

One of the main objectives of the IPVPP, then, is to enhance collaboration between the health, criminal justice, educational and social development sectors, both inside and outside the state, to prevent violence through the adoption of shared strategies.

Objectives

The IPVPPF aims to promote inter-sectoral support for, and collaboration on, the key elements of successful violence prevention approaches, namely:

- Balancing programmatic and policy interventions likely to reduce violence in the short term (such as those that reduce access to lethal weapons, e.g. firearms, and the use of drugs associated with violence and aggressive behaviour, e.g. alcohol), and interventions that affect sustained, long-term change to the social environment and societal norms that support violence (such as programmes for improved early childhood development and positive parenting);
- An intervention approach driven by an accessible evidence base and reliable injury surveillance data;
- The strategic and systematic deployment of prevention resources to target high-risk times, places and groups at-risk;
- Ongoing monitoring of outcomes and risk factors for refinement and improvement.

In addition, the policy supports:

- The establishment of a review and consultation process across relevant departments to align existing performance priorities and deliverables;
- Provision for ongoing consultation with state and non-state actors as well as community organisations and stakeholders;
- The institutionalisation of an inter-sectoral framework that supports and sustains multi-dimensional prevention strategies over a long-term period;
- The design and implementation of programmes and interventions to effect behaviour change.[127]

[127] http://www.westerncape.gov.za/text/2013/September/violence-prevention-cabinet-policy-final.pdf

Violence Prevention through Urban Upgrading Project

The Violence Prevention through Urban Upgrading (VPUU) project is a holistic approach that is unique to Cape Town in that it has integrated all forms of development, not only the physical upgrading of urban spaces. Initiated in 2006 in partnership with the German Government, through the German Development Bank (KFW), the VPUU aims to reduce crime and increase safety levels, and also to upgrade neighbourhoods, improve social standards and introduce sustainable community projects to empower local residents. So far, the project has focused on the improvement of areas in the Khayelitsha "suburbs" of Harare, Kuyasa, Site C/TR section and Site B, creating safe areas for thousands of people. The VPUU has a set of safety principles which are used as guidelines in the upgrading/ development process, and are in line with those of Crime Prevention through Environmental Design.

The project employs various strategies including:
Surveillance and visibility: This entails designing public spaces so that they have clear lines of sight and good lighting to ensure maximum public visibility.

Territoriality: This refers to the sense of ownership a community has over its environment, in turn encouraging residents to become involved in reducing crime.

Defined access and movement: This involves easy access and well-defined routes to, and through, a public place.

Image and aesthetics (dignity): This includes the creation of a positive image of a place, which can be achieved by using appropriate materials, colours, landscaping and lighting to encourage high levels of public activity.

Physical barriers: This relates to the strengthening of building facades and spaces to improve personal safety.

Maintenance and management: This looks at well-managed and maintained environments, which in turn encourage a sense of pride and ownership.

The VPUU uses specific design "tools" to implement its safety principles, including the introduction of a clear signage and way-finding system, creating visual connections along walking routes and ensuring movement routes are as clear and as short as possible, as well as clustering and integrating public activities by ensuring the site layout has active edges, thus increasing passive surveillance. These principles and design tools are used in all areas of the upgrading process to ensure that the main challenge - crime prevention - is addressed. The project is based on a model made up of three "pillars" of development namely: situational crime prevention, social crime prevention and institutional crime prevention.



Violence prevention through urban upgrading. *Photo: Metro Police*

The Victim Empowerment Programme (VEP)

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

Full implementation of the VEP only started in January 1999, however. This programme aims to ensure a victim-friendly criminal justice system, and to abate the negative effects of crime and violence on the victims.

To ensure integrated and co-ordinated services between government departments (at various levels) and civil society, the VEP 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, South African Police Service (SAPS), with the DSD as the lead and co-ordinating department.

The VEMT is responsible for determining strategic direction in regard to the management of the VEP, 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 9.4: 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.

Figure 9.3: DSD framework: victim-centred approach

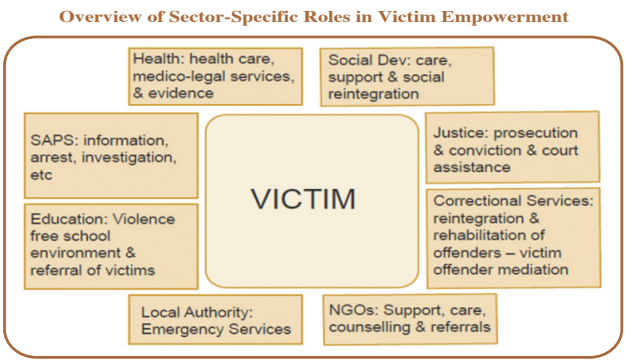


Figure 9.3 demonstrates how the different departments work in unison within a victim-centred approach. The partnership between various government departments and civil society in service delivery to victims of crime is a prerequisite to the success of the integrated VEP. Each structure is expected to develop its own strategies to address the needs of victims. Such strategies should be co-ordinated 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).

Source: Parliamentary Monitoring Group.

Evaluation of the VEP programme by UN Office on Drugs and Crime

The UN Office on Crime and Drugs (UNODC) has noted that the VEP has encountered various challenges since inception, some of which include the lack of monitoring and evaluation mechanisms, 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.

Lack of a strong communication and marketing strategy has also impeded the effective administration of the programme. Although the programme has managed to strengthen co-ordination between government departments and CSOs, several other relevant departments have not been fully involved, e.g. the Department of Education is not actively participating in VEP activities. However, over the years, government has made efforts to strengthen the programmes.

Source: UNODC - South Africa's Victim Empowerment Programme - Final Independent Evaluation 2012.

VEP and training

The DSD notes that capacity building is a major priority for the department requiring due attention. As such, trauma counselling training has been conducted at various government departments and civil society organisations with over 1700 officials benefitting from the training nationally. According to the DSD, 270 social workers were trained in two important programmes aimed at: improving support for victims and including males in preventing gender violence. Social workers were trained in a strategy to guide service providers in how to render services to abused women in shelters. Research such as the Victim Satisfaction and Empowerment study has shown that service providers working with GBV survivors would, like amongst other things, to hire more staff, get better staff training, and have more infrastructure development. The social workers were also trained in ways to include and engage boys and men in preventing GBV. The inclusion of boys and men in preventing GBV is crucial because it is an acknowledgement that males should not be viewed only as possible perpetrators, but also as agents for change in society.

The European Commission has made a commitment of 18.6 million Euro to assist the VEP in the national and provincial DSD's. The funding is intended to assist in the management, co-ordination and leadership of the VEP to effectively improve services to victims of crime especially women and children. As such, financial resources are becoming increasingly available and should be utilised more effectively by government to increase accessibility to services countrywide.

Victim empowerment at provincial level

The following table shows the strategic partnerships in the Western Cape and areas of collaboration.



Table 9.5 Strategic partners within the Western Cape VEP	
Strategic Partnership	**Area of collaboration**
Department of Community Safety	Oversight role regarding the roll-out VEP services by SAPS.
Department of Education	School Safety.
Local Government	Gender programmes and co- funding.
United Nations Office on Crime and Drugs	Programme funding and capacity building.
Department of Health	Programme support through health services.
Department of Correctional Services	Parole board and restorative justice approach.
Department of Justice	Victim charter and witness support services.
National Prosecuting Authority	Thuthuzela services for victims of sexual offences.
Department of Human Settlement	Infrastructure for shelter development.
Department of the Premier	Oversight role.
SAPS	Victim support services at police service centres.
Faith-based organisations	Awareness and prevention services.
Civil Services Organisations and Non-profit organisations	Partners in implementation of victim support services.

Source: Parliamentary Monitoring Group.

Table 9.5 illustrates the importance of having a multi-sector approach to fighting GBV. The different areas of collaboration represent the expert areas of each sector, which when properly co-ordinated, can be harnessed and contribute to a significant change in the prevention and response to GBV.

One stop centres

One stop centres have been established as part of the VEP to offer integrated services to victims of violence, abuse and crime. At these centres, usually located in a medical facility, all relevant professionals (police, medical practitioner and counsellor) see survivors at a single, non-threatening venue. This enables the survivor to relate the incident a minimal number of times and not be expected to travel from one service provider to the next, repeating the traumatic ordeal. The service also facilitates co-ordination between the various criminal justice system agencies, thereby avoiding duplication and evidence-handling mistakes. Unlike the shelters, one stop centres only provide emergency accommodation.

The centres provide a range of services such as counselling, medical attention, legal advice and support to the 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 the victim's situation, he or she may be referred to a shelter if it is deemed risky to send them back home.

The Stop Gender Violence Helpline



The Stop Gender Violence Helpline (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. Callers are given accurate GBV information to facilitate a continuum of care by providing referrals.

NICRO Perpetrators of Intimate Partner Violence programme

The Perpetrator of Intimate Partner Violence (PIPV) programme, offered by the National Institute for Crime Prevention and the Reintegration of Offenders (NICRO), is a domestic violence intervention programme 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 them on how to deal with protection orders and safety plans. Other aspects of the programme are anger and conflict management. The PIPV programme consists of 30 sessions run over 16 weeks, with each session lasting one to three hours.

Conclusion

Addressing GBV requires a multi-sectoral approach for the effective implementation of GBV programmes. This implies having strategies, policies and actions that are inter-sectorally driven. It is encouraging to note that South Africa, like other countries, has made efforts to bring various actors together to take action against GBV. Despite these good intentions, gaps are evident when it comes to committing adequate resources to see the comprehensive actions to fruition. This is against the backdrop of increasing GBV cases in many of South Africa's communities. Compiling fully costed multi-sectoral action plans is a good way to attract meaningful budgets to the goal of ending GBV.

To achieve maximum impact in addressing the GBV scourge, stakeholders in South Africa formed the National Council on GBV which is mandated to provide guidance in the co-ordination of the different sectors that work with survivors of violence. Nevertheless, the council has still to make its impact a formidable force to reckon with in the fight against GBV. The 'whole-of-society' approach adopted by the WCG is a sure way to get all the sectors to focus on the root causes of violence. Another best practice presented in this chapter is the VEP model, which places the victim at the centre.

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. To ensure sustainability of integrated approaches, there is need to strengthen the monitoring and evaluation mechanisms at all levels. Clarity of purpose is also key in the whole chain to avoid duplication of roles by the different sectors.

CHAPTER 10

CONCLUSIONS AND RECOMMENDATIONS



Alma Kritzinger of Mossel Bay Municipality.

Photo: Ntombenthsa Mbadlanyana

Extent

Conclusions

Western Cape has a high prevalence of GBV in both lifetime and the 12 months before the survey. Emotional IPV is the highest form of GBV experienced by women and perpetrated by men in lifetime and 12 months before the survey.

There are high levels of underreporting of GBV in the province. Majority of women who experienced IPV or non-partner violence were less likely to report abuse to the police and health care providers.

Recommendations

- To focus on prevention strategies that seek to address the root causes of violence in both the public and private domains;
- To educate the community to treat violence against women, especially IPV, as a major social problem. The community and individuals need to be encouraged to change the attitudes which promote the culture of silence around these issues;
- Further research exploring the factors that promote under-reporting of VAW should be conducted;
- Stiffer penalties for perpetrators of GBV should be introduced to curb further escalation of VAW;
- Appropriate interventions, such as improvements in service provision by the police and health care providers, should be introduced;
- Mechanisms aimed at reducing the danger of community stigmatisation should be introduced;
- Programmes should be developed that empower women to demand their rights and be able to speak out about their experiences of abuse in the public and private domains.

Drivers and Patterns

Conclusions

- Age, education and employment status are socio-demographic factors that are associated with perpetration and experience of IPV;
- The prevalence of IPV perpetration decreases with increasing age. Young men aged 18-29 years reported more perpetration of VAW compared to men in other older age categories;
- Men with less than high school education are more likely to commit IPV;
- Experience of child abuse influences the perpetration of IPV by men compared to those men who did not experience such abuse;
- Child neglect and sexual abuse increase the risk of men perpetrating non-partner rape;
- Alcohol and drug abuse trigger violence in the province, thereby increasing the risk of IPV perpetration;
- There is low proportion of mentions of GBV by politicians. This implies GBV is not on the political agenda as a social ill that needs attention by leadership. Speeches made do not address emotional and economic violence, implying that government does not sufficiently understand the problems associated with GBV in the country.

Recommendations

- Awareness training, especially to sensitise and educate young men about GBV, should be promoted;
- Patriarchal gender attitudes which promote inequality and subordination of women by men in intimate relationships should be eradicated;
- Strict control measures, particularly in regard to corporal punishment which is taking place illegally behind the closed doors in homes and in schools, should be developed. Parents need to be educated in ways to bring up children in environments that are not harsh to children. This is critical in preventing all forms of child abuse;
- Health promotions that discourage the use of alcohol, should be intensified;
- The current legal drinking age should be revised, and a minimum liquor purchasing age should be introduced;
- Government should regard alcohol abuse as a national priority, introducing and sustaining stiffer penalties for excessive drinking. An upward review of excise duty on alcohol is also needed;
- Politicians should champion the fight against GBV. It is crucial that politicians make regular public pronouncements which are informed by their understanding of the forms and nature of GBV.

Effects

Conclusions

- Women survivors of VAW in the Western Cape are prone to physical injuries, hospitalisation, loss of days from work, poor mental health, stigmatisation, and increased risk of HIV and STIs;
- GBV has adverse effects on families and can ultimately result in death or disability.

Recommendations

- The health system should be strengthened in order to be responsive to current WHO clinical and policy guidelines on IPV and sexual violence. Prompt screening of GBV survivors to ensure improved access to appropriate medical care is needed;
- Government should take the lead in prioritising mental health through provision of adequate funding, appropriate infrastructure and human capital to psychiatric and mental health services;
- A holistic approach should be adopted that takes on board the media, health services, policy makers and social services in responding to, as well as preventing GBV;
- Communities should be more supportive of survivors of VAW.

Response and support

Conclusions

- Government has made significant strides in offering protection by establishing structures that focus on the survivors of GBV. The major departments mandated to assist survivors of violence are the police, justice, social services and health;
- Provision of shelters and economic empowerment are other ways to assist survivors of GBV. There are few shelters which offer support to survivors of GBV in the Western Cape.

Recommendations

- Constant monitoring and evaluation of the policies relating to violence to ensure effective prevention should be implemented, along with adequate response mechanisms;
- Government should increase funding to existing shelters, VFRs, and other GBV-related initiatives in the Western Cape;
- More new places of safety should be established to cope with the increasing demand of GBV survivor services.

Prevention

Conclusions

- Factors that increase the risk of violence are multi-faceted in nature. These often include the perpetuation of conservative individual and community attitudes on gender equality, alcohol and drug abuse, child abuse and socio-economic issues such as age appropriateness and education;
- The Western Cape recorded a high percentage (83%) of women who are aware of prevention campaigns and laws. This is an encouraging trend that should be sustained, however further studies are needed to establish if there is any link between awareness of campaigns and VAW prevention;
- Working with men and traditional leaders is key to challenging traditional norms and practises that perpetuate male dominance in all spheres;
- Strong and sustained political will and commitment is critical in the implementation of violence prevention strategies.

Recommendations

- Government and civil society should undertake a paradigm shift from a responsive perspective to a proactive one in addressing all factors influencing violence in the society;
- More emphasis should be placed on mobilising communities, especially in rural areas, to challenge gendered ideas of masculinity;
- It is critical to implement secondary and tertiary interventions which prevent recurring acts of perpetration;
- Deliberate strategies which encourage women to participate in the campaigns relating to GBV should be developed;
- It is critical to encourage women not only to know about the legal provisions and campaigns that

protect them, but to embrace and uphold them in order to prevent further abuse and re-victimisation.

Integrated approaches

Conclusions

- The South African government compares favourably with other SADC countries in terms of action plans to help end GBV. Significant strides have been made in compiling plans such as the 365 Days National Plan of Action, the National Council against GBV and The Integrated Victim Empowerment Policy, among others;
- Western Cape government developed the provincial integrated violence prevention policy framework which employs "whole-of-society" approach in preventing violence;
- These plans are impeded by lack of adequate funding, poor planning, lack of co-ordination, accountability and capacity, and confusion in terms of demarcation of responsibilities among the stakeholders. This affects effective execution of GBV strategies;
- The National Council Against GBV has been created to co-ordinate the activities of different actors in GBV-related spheres in the country. The council is yet to make a meaningful impact.

Recommendations

- Government should adequately fund the implementation of the action plans and other initiatives related to ending GBV;
- Fully costed action plans should be developed to ensure accountability and also to access budgets;
- Best practises should be used in educating and increasing capacity of the personnel involved in the planning, co-ordination and implementation of action plans related to GBV;
- Government should develop a dedicated monitoring and evaluation framework that can be utilised by organising committees involved in the various action plans.

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The Western Cape GBV Indicators Study provides the first comprehensive baseline data on violence against women in the province. It shows that 39% of women have experienced some form of violence in their lifetime, and that the same proportion of men admit to perpetrating violence. Most of this violence takes place where all citizens should feel safest – in the home and in communities. The highest proportion of violence is the kind for which there is no category in police records – emotional, verbal and economic abuse. This is the slow but debilitating death that many women experience daily, undermining their agency and ability to participate fully and meaningfully in public life. Twenty years into our democracy the report is a shocking wake up call to politicians and the public alike. The Western Cape is the fourth province (with Gauteng, Limpopo and Kwa Zulu Natal) to have undertaken this study. The report is a reminder that South Africa needs to upscale all the provincial reports into a national GBV Indicators Study to serve as a baseline for measuring progress in eradicating the most flagrant remaining violation of human rights post- apartheid.

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