The Gender Based Violence Indicators Study

KwaZulu-Natal Province of South Africa

November 2013

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

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

GBV Indicators Research in KwaZulu-Natal Province

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Acknowledgements

The Gender-Based Violence Indicators Project is a regional research study aimed at testing tools to measure and monitor the extent, effect, cost of, and efforts to end violence against women in light of the Southern African Development Community (SADC) Protocol on Gender and Development's target to halve levels of gender-based violence by 2015. Researchers conducted this study in KwaZulu-Natal province of South Africa in 2011 and 2012.

Our appreciation goes to the nearly 1300 women and men who consented to participate in this study.

GL is especially indebted to the 11 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.

GL gives special thanks to Umgeni Commmunity Empowerment Centre, The Haven and Esther House for assisting in collecting the *"I" Stories*. The voices of those most affected give this study power and urgency.

GL also commends Umhlaba Development Services for training researchers and overseeing the data collection of the prevalence and attitudes survey. Fourteen research assistants visited households and administered survey questionnaires in the KwaZulu-Natal province.

Thanks to Quintin Spies and Carl Fourie who programmed questionnaires and equipment. Spies provided invaluable technical support including the training of researchers on the use of the Personal Digital Assistants (PDAs).

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

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

GL worked with the South African Medical Research Council (MRC) in the conceptualisation of the prevalence and attitudes household survey. Professor Rachel Jewkes, Director of the MRC Gender and Health Research Unit, and Nicola Christofides, initially with the MRC and later a senior lecturer at the University of the Witwatersrand School of Public Health, advised on and developed the survey research methodology and instruments. Nwabisa Jama Shai, former GL GBV Indicators Research Manager, contributed to the development of research tools.

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Acronyms

AIDS	- Acquired Immune Deficiency Syndrome
AGC	- Africa Gender Centre
ANC	- African National Congress
ARV	- Anti-retroviral drugs
BPA	- Beijing Platform for Action
CBO	- Community-Based Organisation
CC&DW	- Creative Consulting & Development Works
CEDAW	- Convention for the Elimination of Discrimination Against Women
CEO	- Chief Executive Officer
CGE	- Commission for Gender Equality
COE	- Centres of Excellence
CSO	- Civil Society Organisation
CSVR	- Centre for the Study of Violence and Reconciliation
DAC	- District Local AIDS Council
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 Areas
FAMSA	- Families South Africa
FBO	- Faith based Organisations
FCS	- Family Violence, Child Protection, Sexual Offences
FVSA	- Family Violence and Sexual Abuse
GBH	- Grievous Body Harm
GBV	- Gender-based violence
GDP	- Gross Domestic Product
GEMSA	- Gender and Media Southern Africa Network
GL	- Gender Links
GCIS	- South African Government Communication and Information System
GMPS	- Gender and Media Progress Study
LMs	- Local Municipalities
HIV	- Human Immuno Deficiency Virus
ICD	- Independent Complaints Directorate
IDMT	- Inter-Departmental Management Team
IPID	- Independent Police Investigative Directorate
IPV	- Intimate partner violence
IVEP	- Integrated Victim Empowerment Policy
JCPS	- Justice Crime Prevention Strategy
KZN	- KwaZulu-Natal
MAP	- Man As Partners
MRC	- Medical Research Council
NGO	- Non Governmental Organisation
NAP	- National Action Plan to end violence against women and children
NCPS	- National Crime Prevention Strategy
NDOH	- National Department of Health
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
NVEP	- National Victim Empowerment Programme
OMC	- One Man Can
OVC	- Orphans and Vulnerable Children
PAC	- Provincial AIDS Council
PCI	- Project Council International
PDA	- Personal Digital Assistant
PEP	- Post Exposure Prophylaxis
PIA	- Prevention in Action
PIPV	- Perpetrator of Intimate Partner Violence
PO	- Protection Order
PTSD	- Post-Traumatic Stress Disorder
PSU	- Primary Sampling Unit
SADAG	- South African Anxiety and Depression Group
SADC	- Southern African Development Community
SALGA	- South African Local Governance Association
SANAC	- South African National AIDS Council
SANCA	- South Africa National Council on Alcoholism and Drug Dependency
SAPS	- South African Police Services
SGVH	- Stop Gender Violence Helpline
SOA	- Sexual Offences Act
SOCA	- Sexual Offences and Community Affairs Unit
SOC	- Sexual Offense Courts
SSO	- Survivor Support Officer
STATSSA	- Statistics South Africa
STI	- Sexually transmitted infections
TCC	- Thuthuzela Care Centre
TLAC	- Tswaranang Legal Aid Centre
UCEC	- Umgeni Community Empowerment Center
UN	- United Nations
UNECA	- United Nations Economic Commission for Africa
UNIFEM	- United Nations Development Fund for Women
UNWOMEN	- United Nations Entity for Gender Equity and the Empowerment of Women
VAW	- Violence against women
VCT	- Voluntary Counselling and testing
VCCT	- Voluntary Counselling and confidential testing
VEC	- Victim Empowerment Centre
VEMT	- Victim Empowerment Management Team
VEP	- Victim Empowerment programme
VFR	- Victim Friendly Rooms
VFU	- Victim Friendly Unit
WHO	- World Health Organisation

The Management and Research Team

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

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

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

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

Ntombentsha Mbadlanyana joined Gender Links as the Gender Justice and Local Government Facilitator on the 1 March 2010. Before she joined Gender Links she had worked for the Provincial Government of the Western Cape in the Department of Social Development, Head Office and worked for the Directorate: Social Capital Formation. She is also a researcher, facilitator, gender activist and an academic with qualifications in Social Sciences. She holds a BA in women's and 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 also studying towards completing her MA in women's and gender studies. After having completed her studies she worked as an intern at RAPCAN - an NGO in Cape Town that deals with the eradication of child abuse and neglect. She has also volunteered at the Triangle Project an organisation that works in Lesbian, Gay, Bisexual & Transgendered (LGBT) issues.

Violet Nyambo is the monitoring and evaluation intern. She has worked as an interviewer in various HIV and AIDS research projects at the UZ-UCSF Collaborative Research in Women's Health Programme in Zimbabwe. Her work experience is complemented by a master in demography and population studies from the University of the Witwatersrand. She has gained extensive knowledge in qualitative and quantitative data management and analysis. She is also a 2012 Hewlett Foundation Fellow. She also holds an honours degree in community development from the University of Pretoria. Her main interests are in sexual reproductive health research, namely family planning.

Foreword

Chairperson of Commission for Gender Equality, Mfanoezelwe Shozi. *Photo: GCE*

The GBV Indicators Research study of KwaZulu-Natal provides the first comprehensive baseline data on the extent and patterns of violence against women (VAW) in the province.

37% of women surveyed reported experiencing some form of gender violence in their lifetime in KwaZulu-Natal. Some 42% of men surveyed provided corroborating evidence of perpetration. The higher figure for men is itself a telling statement of the fact that men in our society freely acknowledge violent behaviour, even more so than women admit experiencing such violence.

Domestic violence is pervasive as about a third (31%) of the women has experienced intimate partner violence in their lifetime. Additionally, a very high proportion of women and men have suffered various forms of childhood abuse. The findings show that the domestic sphere, which should be an arena of protection and safety for women and children, is one of the most dangerous places.

Indeed, peace has to start at home, for the province to meet the SADC Protocol on Gender and Development target of halving GBV by 2015. It is the responsibility of each individual in the province to be an agent of ending gender violence in their private and public lives. The change in attitude towards norms which promote gender violence at an individual level will certainly extend to the community and the society at large.

It is commendable that various actions plans to end GBV have been set up in the country. The 365 Days National Plan of Action, the National Council against GBV and the Integrated Victim Empowerment Policy are some of the commendable initiatives the government is implementing. Adequate monitoring is vital for the effective implementation. This study, one of a series now conducted in four provinces of South Africa, is a reminder of the need for a national survey on the extent, causes, effects, responses and efforts to prevent GBV.

If we accept that GBV is the single most flagrant violation of human rights in South Africa post democracy, we must also accept that there is need to invest government resources in establishing the true extent of this scourge, and what needs to be done to end it, once and for all. We call on the National GBV Council to take up this initiative, and escalate it to national level. We call upon Family Structures, KZN Traditional leaders and faith based organisations and Employers to use the report to uproot the scourge of GBV. We call upon all men across all to take the centre stage to reverse the issues raised by the study. The KZN Men's Forum should take a lead and work with all men to deal with Gender Based Violence.

The Commission for Gender Equity believes that there has been some improvement in societal attitudes toward women in the last two decades. Since the advent of democracy in South Africa, the government has put in place a variety of policy initiatives, legislative frameworks and national strategies to combat violence. The country has also signed up to and ratified numerous regional, continental and global/ international declarations, protocols and treaties aimed at protecting the rights of vulnerable groups, particularly women and children. However, there is still too big a disjuncture between the rhetoric of gender equality, and the reality on the ground. I see this research as contributing to CEDAW General Recommendation 19, which calls upon member states to put strategies in place to address GBV and this research report will assist KZN government to tackle these issues from the informed position.

GBV work has been indirectly treated by Provincial Governments and Municipalities as a National competency. This report will force the KZN government to prioritise and mainstream GBV work across various programmes.

As the Commission, we believe strongly that these findings will not only lead to informative discussions with the relevant stakeholders in KwaZulu-Natal, and broader gender sector, but they will inform policy discussions, programme implementation and way forward on the future of Gender Based Violence approach. If this report is used effectively to inform our work, institutions or policy programmes designed to address the high levels of violence against women and children in South Africa would be effective.

I take this opportunity to thank all partners who took part and contributed to this research, and to the sponsors - UKAID and FOKUS. Together we can end gender violence and take South Africa forward. *Yes we can, and yes we must!*

Executive Summary

South Africa has several ratified instruments that vie for the elimination and protection of women from all forms of violence. The country has also enacted key legislation, such as the Domestic Violence Act, 1998 (Act No 99 of 1998), and the Sexual Offences and Related Matters Amendment Act, No. 32 of 2007. However, women from all backgrounds, ages and socio-economic status in KwaZulu-Natal, a province characterised by high HIV and AIDS prevalence, have experienced violence perpetrated by men in both their private and public lives.

Thirty seven percent of women in KwaZulu-Natal (KZN) have experienced some form of gender-based violence in their lifetime, including partner and non-partner violence. Forty three percent of men admit to perpetrating some form of violence against women.

The forms of violence encountered include physical, sexual, psychological and economical abuse. 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 intimate partner violence (IPV) in their lifetime. The predominant form of violence within intimate relationships is psychological, which includes insults, belittling and verbal abuse. A quarter (25%) of women experienced emotional IPV. Women also reported physical IPV (24%), economic IPV (15%) and sexual IPV (12%). For all forms of violence, a greater proportion of men admitted to perpetrating emotional IPV (35%), physical IPV (29%), economic IPV (20%) and sexual IPV (14%).

Violence is also highly prevalent in existing relationships. Sixteen percent of women experienced, while 22% of men perpetrated, some form of IPV in the 12 months prior the survey. These findings confirm that violence in intimate relationships is a reality within KZN.

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 been raped by non-partners while 12% of men admitted raping a non-partner in their lifetime. Five percent of the women who had ever worked had been sexually harassed at work, while two percent of women had been sexually harassed at school. Eighteen percent of women experienced some form violence during pregnancy.

While violence against women is evident in KZN communities, the majority of female victims do not report violence to police, seek medical attention or legal recourse. Five percent of women who had been physically abused reported it to police, while just four percent reported the incident to medical providers. Of those women who had been raped by a non-partner, less than one percent 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 said rape survivors can often be seen as responsible because they are promiscuous. More than a quarter of men (27%) and 17% of women blame the rape survivor for the rape. In addition to the negative community responses to victims of domestic violence and rape, other barriers identified include the inaccessibility of services and sometimes the risk for secondary victimisation by service providers.

The above feedback constitutes some of the key findings from the GBV study conducted by Gender Links in KZN, South Africa between 2011 and 2012. The study combined quantitative and qualitative methods to better understand the extent, effects, responses and prevention of GBV within the KZN context. GL conducted a cross-sectional prevalence and attitudes household survey in 2011. Researchers collected administrative data from criminal justice systems, health care services and government-run shelters. They gathered qualitative data through first-hand accounts of women's experiences of GBV. They also collected data from media monitoring exercises, political speeches and discourse analysis. This study presents the main findings in five categories: extent of GBV; patterns and drivers; effects; support; and prevention of GBV. They include:

Table I: Extent of GBV in KZN

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	36.9	42.6	-	-
Prevalence of intimate partner violence	30.6	44.0	15.9	21.5
Prevalence of emotional intimate partner violence	25.1	35.3	9.5	14.9
Prevalence of physical intimate partner violence	23.9	28.9	10.5	9.6
Prevalence of economic violence	15.2	19.7	8.0	8.6
Prevalence of sexual violence	12.0	14.0	4.1	6.7
Prevalence of non-partner rape	3.6	11.8	1.5	0.9
Prevalence of attempted rape	2.2	1.9	0.8	1.6
Prevalence of abuse in pregnancy	18.0	-	-	-
Prevalence of sexual harassment	6.3	-	-	-
Prevalence of sexual harassment at school	5.0	-	-	-
Prevalence of sexual harassment at work	2.3	-	-	-

Table I shows:

- Of all the women interviewed in KwaZulu-Natal, 37% experienced, while 43% of men perpetrated, GBV in their lifetime;
- IPV is the most common form of GBV experienced by women, with 31% women having experienced it in their lifetime and 16% 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;
- About a tenth (11%) of women experienced physical violence in the year prior to the survey;
- Eighteen percent of women experienced some form of abuse during pregnancy;
- Six percent of women had experienced sexual harassment in their lifetime; and
- In most indicators, men admitted perpetrating violence more often than women admitted experiencing violence.

Patterns and drivers of GBV

The ecological framework (Heise, 1998) is used to illustrate risk factors of experience and perpetration of IPV. The study 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	30.0	0.3	36.3	0.03	13.8	0.8	22.1	0.6
30-44	37.5		48.8		18.4		22.9	
45+	24.6		51.5		15.1		17.3	
Level of education								
High school incomplete and lower	29.3	0.7	53.7	0.0007	14.4	0.7	24.5	0.1
High school complete and over	32.5		32.4		18.0		17.0	
Worked in past 12 months								
No	29.0	0.4	44.8	0.7	16.4	0.8	19.9	0.5
Yes	34.0		43.3		14.9		22	

Table II shows:

- Perpetration of IPV positively correlates with age in lifetime experiences, with men aged 45 and older more likely to report abusing an intimate partner;
- Age, level of education and employment status are not associated with IPV among women in GBV experiences in lifetime or 12 months prior to the study. This implies that all women remain vulnerable to IPV;
- There is no statistical difference in the proportion of women raped by a non-partner according to age, level of edu-cation and employment status in lifetime experiences;
- The proportion of women who worked 12 months prior to the survey and who had been raped is significantly higher than the proportion of unemployed women who had been raped (p=0.05); and
- Men who did not complete high school reported significantly higher levels of non-partner rape (54%) than men who completed high school (32%).

Childhood abuse

The majority of women and men who took part in the study had been abused as children. Seventy-one percent of women and 76% of men experienced some

form of abuse during childhood. More than half (55%) of women and 69% of men experienced physical abuse in childhood. The study explored whether experience of child abuse is associated with IPV perpetration by men.

Table III: Child abuse as a risk factor of perpetration of IPV				
Factors	**IPV**		**Non-partner rape**	
	% men perpetrating	p value	% men perpetrating	p value
Any child abuse				
No	20.8	0.0002	2.5	0.0004
Yes	50.9		14.7	
Child physical abuse				
No	22.9	0.000	11.9	0.99
Yes	53.4		11.8	

Factors	IPV		Non-partner rape	
	% men perpetrating	p value	% men perpetrating	p value
Child sexual abuse				
No	44.5	0.8	8.1	0.005
Yes	41.3		27.5	
Child neglect				
No	29.7	0.0009	3.4	0.000
Yes	56.6		19.2	

Table III shows:

- Child physical abuse and child neglect can be linked to perpetration of IPV;
- There is a statistically significant difference in perpetration of IPV between survivors of child physical abuse and non-survivors. More than half (51%) of men who had been physically abused as children reported perpetrating IPV whereas 20% of men who did not experience physical abuse committed IPV;
- A significantly higher proportion of men who had been victims of child neglect (57%) committed IPV compared to those who had not been victims (30%);
- A significantly higher proportion of male survivors of child neglect and sexual abuse perpetrated more non-partner rape than non survivors;
- Nearly a fifth (19%) of survivors of child neglect perpetrated non-partner rape while three percent of non-survivors of child neglect admitted the same offense; and
- Twenty-eight percent of male survivors of child sexual abuse committed non-partner rape whereas

  eight percent of non-survivors of child sexual abuse also committed non-partner rape.

Alcohol and drug use

- Alcohol and drug use is associated with IPV perpetration in the 12 months preceding the survey;
- A significantly higher proportion of men who drank alcohol (30%) perpetrated IPV when compared to men who did not drink (14%); and
- About one in three (34%) male drug users and 16% of non-drug users committed IPV 12 months prior to the survey.

Relationship factors

Generally, the attitudes that support male dominance and patriarchy remain triggers of violence against women.

Community factors

Table IV: Personal gender attitudes		
	Women strongly agree %	Men strongly agree %
Gender relations		
I think a woman should obey her husband	85.3	91.4
I think people should be treated the same whether they are male or female	82.0	76.0
I think this a man should have the final say in all family matters	51.5	69.9
I think a woman needs her husband's permission to do paid work.	50.1	44.2

	Women strongly agree %	Men strongly agree %
I think that there is nothing a woman can do if her husband wants to have girlfriends	46.0	34.9
Sexual entitlement		
I think it is possible for a woman to be raped by her husband	48.1	48.9
I think that if a man has paid lobola for his wife, he owns her	38.1	50.2
I think that a woman cannot refuse to have sex with her husband.	36.5	43.9
I think that if a wife does something wrong her husband has the right to punish her	35.5	43.3
I think that if a man has paid lobola for his wife, she must have sex when he wants it	29.7	44.7
Attitudes towards rape		
I think it is possible for a woman to be raped by her husband	48.1	48.9
I think that in any rape case one would have to question whether the victim is promiscuous	23.4	55.6

Table IV shows:

- High proportions of women (85%) and men (91%) agree that a woman should obey her husband;
- More women (82%) than men (76%) feel that people should be treated the same despite their gender;
- A greater proportion of men than women think that a husband has sexual entitlement;
- Thirty-eight percent women and 50% of men agreed that if a man paid *lobola*, he owns his wife;
- Thirty-six percent women and 43% men believe a husband has the right to punish his wife is she does something wrong; and
- More men than women exhibited attitudes which blame and stigmatise rape survivors. Fifty-seven percent men compared to 23% women feel that one has to question whether the rape victim had been promiscuous.

Societal factors

Political environment

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

Table V shows:

- Of the 2238 speeches issued from April 2010 to March 2011, only seven percent referred to GBV;
- The most mentioned form of GBV is physical abuse (51%), while the least discussed is emotional abuse (6%);
- Political leaders mentioned domestic violence in 31% of the speeches on GBV; and
- Eleven percent of the speeches on 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	26
Percentage of physically injured women who spend days in bed because of injuries	13
Percentage of physically injured women who missed work as a result of injuries	6
Sexual and reproductive health	
Percentage of women who had been sexually abused by intimate partners and diagnosed with STI	19.2
Percentage of women who had been physically abused by intimate partners and diagnosed with STI	26
Percentage of women who had been raped by non-partners and diagnosed of STI	33.4
Percentage of women who had been physically or sexually abused by intimate partners and tested HIV positive	35.2
Percentage of women who had been raped by non-partners and tested HIV positive	33.7
Poor mental health	
Percentage of women who had been abused by intimate partner and suffered depression	67.5
Percentage of women who had been raped by non-partner and suffered depression	67.9
Percentage of women who had been abused by intimate partners and attempted suicide	9.9
Percentage of women who had been raped by non-partners and attempted suicide	19.3

Table VI shows:

Physical injury

- Twenty-six percent of women who had been physically abused in the survey suffered injuries; and
- Thirteen percent of the women who experienced physical abuse sustained serious injuries and had been bedridden.

Reproductive health effects

- Nearly a fifth (19%) of women who had been sexually abused by an intimate partner had an STI;
- About a quarter (26%) of women who had been physically abused reported significantly higher levels of having STIs;
- A third (33%) of women who had been raped by a non-partner in their lifetime had been diagnosed with an STI;

- Thirty-five percent of women who had been physically or sexually abused by an intimate partner tested HIV positive; and
- A significantly higher proportion of IPV survivors reported an HIV-positive status when compared to non-survivors.

Mental health effects

- An equal proportion (68%) of non-partner rape and IPV survivors suffered from depression 12 months prior to the study;
- Ten percent of IPV survivors attempted suicide; and
- Nearly a quarter (19%) of women raped by non-partners attempted suicide.

Costs of GBV

It is difficult to determine accurate amounts of money spent on GBV because of the difficulty accessing data due to bureaucratic constraints and poor recording systems. The estimated cost of running a Thuthuzela Care Centre (TCC) per annum in KwaZulu-Natal, derived from the Department of Justice and Constitutional Development data, is R4 089 312.

Response and support

Table VII: Response and support indicators

Criteria	% women	% men
Awareness of legislation		
Proportion of participants aware of the Domestic Violence Act	79.1	68.3
Proportion of participants aware of Sexual Offences Act (SOA)	22.6	48.6
Proportion of participants aware of protection orders	57.5	63.5
South African Police Services (SAPS)		
Number of rape cases recorded by SAPS in 2011/2012	9026	
Number of sexual assault cases recorded by SAPS 2011/2012	1520	
Number of sexual offences detected by police 2011/2012	934	
Number of other contact sexual crimes recorded by SAPS 2011/2012	423	
Number of attempted sexual offences recorded by SAPS 2011/2012	388	
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 (FCS)	25	
Number of Victim Friendly Rooms (VFCs)	142	
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 Endedale TCC	895	
Number of new cases received at Madaleni Hospital	984	
Number of new cases received at Pergville project	23	
Number of cases received at Estcourt Hospital	178	
Number of GBV cases recorded at Lifeline from 2011-2012	10 970	
Number of women received at Lifeline who had been abused by intimate partner from 2011-2012	4 507	
Number of child sexual abuse received at Lifeline from 2011-2012	1 434	
Number of rape cases received at Lifeline from 2011-2012	1 123	

Table VII shows:

Awareness of laws

- More women (79%) than men (68%) are aware of the Domestic Violence Act;
- A relatively low proportion of those interviewed - 23% women and 49% men - knew about the Sexual Offences Act; and
- Fifty-eight percent women and 64% of men had heard about protection orders.

South African Police Services

- The SAPS recorded 9 026 rape cases, 1520 sexual assault cases and 388 attempted sexual assault cases in 2011/2012;
- The SAPS created 25 family violence, child protection and sexual offences (FCS) units in KwaZulu-Natal. These offer specialised services to deal with domestic violence at police stations;
- About 142 Victim Friendly Rooms (VFCs) exist. These spaces offer private and comfortable environments for survivors to be informed about their rights following a case of GBV;
- There is a marked difference in interim protection orders and final protection orders granted; and
- For the year 2011, police granted 217 987 interim protection orders and 87 711 final protection orders.

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	34.8	82.8
Proportion of participants who had heard of the 365 Days campaign in the 12 months prior to the survey	17.5	66.0
Proportion of participants who had ever participated in a march or event in protest against GBV	9.2	17.5
Proportion of participants who had accessed information about GBV from a radio programme	32.3	43.5
Proportion of participants who had accessed information about GBV from a television programme	38.3	18.7
Proportion of participants who had accessed information about GBV from newspapers	9.9	25.2

Table VIII shows:

- Thirty-five percent of women, compared with 83% of men, had heard about the 16 Days of Activism campaign in the 12 months prior to the survey;
- Eighteen percent of women and 66% of men had heard about the 365 Days campaign;
- Very few women (9%) and men (18%) had participated in a march or event in protest against GBV;
- Thirty-eight percent of women and nearly a quarter (19%) of men had received information about GBV from a television programme; and
- More men (25%) than women (10%), received information about GBV from a newspaper.

Table IX: Conclusion and recommendation	
Conclusions	**Recommendations**
Extent	
KwaZulu-Natal has a high prevalence of GBV. IPV is the highest form of GBV experienced and perpetrated by women and men respectively in lifetime and 12 months before the survey.	There is a need to strengthen interventions towards empowering women and improving their status in the province.
	There is need to create a society which is not tolerant to IPV. This can be done through educational campaigns which inform women of their rights. Raising awareness in the community of the negative consequences of IPV is also essential.
	Legislation should enforce stiffer penalties for perpetrators of GBV, especially against women.
Underreporting of GBV is prevalent in the study. Women who experienced IPV or non-partner violence are less likely to report their ordeals to the police and medical health care providers.	There is need to research the barriers hindering reporting of GBV to the police and medical practitioners. Interventions should include improvements in service provision by the police and medical practitioners and reducing the risk of community stigmatisation.
	Women need to be empowered and encouraged to speak out about their experiences of abuse.
Drivers and patterns	
Factors associated with perpetration of IPV in lifetime include age and education. The prevalence of IPV perpetration increased with age. Men with less than high school education are more likely to commit IPV.	Interventions which target men in their childhood years and intensify during adolescence are crucial to sensitise and educate men against GBV.
	There is a need for civil society and government to campaign, and educate the community, against community norms and values that promote GBV.
Child abuse increased the risk of IPV perpetration. Men who had been physically abused and neglected in childhood are more likely to perpetrate IPV than men who did not face such abuse. Child neglect and sexual abuse increase the likelihood that a man will perpetrate non-partner rape.	There is a need to prioritise prevention and rehabilitation programmes for survivors of child abuse to prevent the cyclical nature of violence.
	It is crucial to educate the community on promoting healthy and happy family environments.
Alcohol and drug abuse increase the risk of IPV perpetration.	Health promotions which discourage the excessive use of alcohol in the community remain essential.
	Alcohol consumption should be regulated by law. This can be done through enforcing stiffer penalties for excessive drinking and IPV. There is need for higher alcohol tax and regulation of drinking points.
Government is still a long way from sufficiently addressing GBV in the province as evidenced by the low proportion of mentions of GBV in political speeches. Additionally, the speeches imply that government does not sufficiently understand the problems associated with GBV in the country.	Politicians need to lead in the fight against GBV and this should be illustrated by regular public pronouncements. Politicians need to be aware of the forms and nature of violence in order to adequately address the issue in public discourse.

Conclusions	Recommendations
Effects	
Women who experience IPV remain at increased risk of injuries, mental health problems and STIs, including HIV. The end result of GBV is death or disability.	The health sector should integrate the new clinical and policy guidelines from the World Health Organisation on how to respond to IPV and sexual violence. Early screening of survivors is crucial in order to implement appropriate medical care.
	There is a need for the community and government to realise that mental health is a serious health problem. Adequate funding, appropriate infrastructure and personnel remain critical in dealing with the challenge of mental health.
Response and support	
Provision of shelter and economic empowerment are some of the ways to help survivors of GBV. However, the few shelters in KZN face serious financial contrasts and understaffing.	Government should increase funding to existing shelters and other GBV-related initiatives in the province, including establishing new places of safety.
Prevention	
A complex set of factors increase the risk of violence. These include the need to perpetuate conservative community and individual beliefs, alcohol and drug abuse, child abuse and socioeconomic factors such as age and education.	There is a need to develop primary prevention strategies which address all factors influencing violence in the society. The prevention strategy should include proactive and responsive strategies to ensure effectiveness.
	The civil society and government should mobilise the communities to eliminate attitudes which promote gendered ideas of masculinity, especially in rural areas.
	It is important to emphasise the need to implement secondary and tertiary interventions which prevent recurring acts of perpetration.
Prevention campaigns and prevention laws are not well known, especially among women.	Better strategies which encourage women to participate in the campaigns relating to GBV need to be formulated by civil society groups and the government.
Strong political will and comment is essential in the implementation of violence prevention strategies. The government has allocated about R16 million towards GBV in 2013/2014.	There is a need for government to continue supporting efforts towards eradicating GBV through allocation of sufficient resources and action towards ending GBV.
Integrated approaches	
South Africa, when compared to other SADC countries, has done the most in terms of coming up with action plans to help end GBV. These plans include the 365 Days National Plan of Action, the National Council against GBV and The Integrated Victim Empowerment Policy among others. However, these plans have not yet been fully implemented. Some of the reasons for poor implementation include lack of adequate funding, poor planning, lack of coordination, accountability and capacity, and confusion in terms of demarcation of responsibilities among the stakeholders.	Government should provide adequate funding for implementation of the action plans among other initiatives related to GBV.
	Initiatives should be taken to educate and increase capacity of those involved in the planning, coordination and implementation of action plans on GBV on appropriate actions for successful implementation.
	The organising committees of the various action plans should set up a monitoring and evaluation framework.

CHAPTER 1
INTRODUCTION

Women participate in a team-building event during the 17th Conference of the Parties (COP17) to the United Nations Framework Convention on Climate Change in Durban.
Photo by Trevor Davies

Key facts

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

My parents got divorced before I (Becka) was born. They divorced because my father was a drug addict. I lived with my grandmother and mother. Later on my mother remarried and moved out. I had a good childhood and turned out to be an independent, successful woman.

I met my husband when I went to my cousin's place in Johannesburg for the Easter holidays. He was a friend of my cousin's husband. Although I was reluctant to date him initially, we ended up together and subsequently married.

In the Hindu custom the man must buy jewellery for the woman, but he didn't buy it for me, stating money as the excuse. It didn't matter to me because I am not materialistic. Instead my parents bought the jewellery for me. He made me pay for our honeymoon because he didn't have money.

On the day of marriage my husband's family said my stepfather was not allowed to attend on the basis that he was a white man. My in-laws did not want my mother to participate in the rituals. After our marriage his family never welcomed me but instead they started making jokes about my surname. They also ridiculed me because of my stepfather.

We moved to our own flat. My husband would check the food, measuring how much I was eating. This went on for days until I asked him about it and he got angry. He kept on pressurising me, trying to take my investment money, but I refused and he would threaten to throw me from the seventh floor so that he could take it since we were married in community of property. He also wanted to take my jewellery that my parents had bought for me. He said he would tell people that I had committed suicide. I took out all my money and gave it to him although my parents were against it. However, I refused to give him my jewellery. He didn't want me to work and told me a woman's place is at home. He is a man and I must do what he says.

He used to physically abuse me. He said I should just clean and cook for him and his child and then leave the house. So it was like that every weekend. It went on for some time until I got angry and said enough is enough and walked out and came to Durban. He followed me and apologised and said he won't do it again. I went back to Johannesburg again. We stayed in Johannesburg for a year as he was trying to start a business. He ended up leaving his job and life was tough for us. After he lost his job we returned to Durban, where he got a job.

After a long time of trying for a baby and some prayers, I fell pregnant with a baby girl. This angered him because he wanted a baby boy and he made me sleep on the floor, but I never told anyone because I knew they wouldn't believe me because he is a pretender. This went on until I gave birth. I had a complication during delivery. He insulted me that I was a useless mother, I couldn't give birth properly and I believed him and even blamed myself.

He started having an extra-marital affair and began gambling using a loan from the bank. He came home late at night and spent less time at home. He took the car that my aunt had given me.

When our child was two and half months, he went to court to file for divorce. My attorney filed for maintenance, a protection order and requested the car. My husband won the case and he kept the car. However, he had to pay maintenance for me and the child.

After one year he came and asked for forgiveness. He promised to stop gambling and beating me up. I accepted him back.

Becka's story typifies the ordeal many women suffer at the hands of an intimate partner, right from the onset of a relationship. She is emotionally, physically and economically abused. Like many women, she finds herself trapped in the vicious circle of IPV as her husband apologises and promises to change. However, he always goes back to his old ways. The story also sheds light on the effects of GBV to the victim and to any children involved. She feels useless and blames herself for those misfortunes that befall her.

This report outlines the background, methods and findings of the GBV Baseline study conducted by GL in 2011 and 2012 in the KwaZulu-Natal province of South Africa. More specifically, this opening chapter outlines the regional background and rationale for the GBV baseline study in KZN, its unique features, country context and previous related research.

Background and rationale

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

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

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

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

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

The UN Economic Commission Africa Gender Centre (UNECA/AGC) commissioned desktop research for the rest of Africa following similar methods used by GL and partners for the pilot project. The Centre for the Study of Violence and Reconciliation found gaps in the data collected by many different countries on GBV by looking at administrative data collection and situational analysis. Some countries do not even have recording systems on any aspect of VAW. Laws in various countries do not regard certain acts of GBV as punitive violations, thus making it difficult for countries to speak the same messages on GBV. This is taking place despite the fact that lawmakers in most countries unanimously agree that GBV is a gross violation of human dignity and have made demonstrable strides in combating its existence, mainly through ratification of tools such as the SADC Protocol on Gender and Development.

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

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

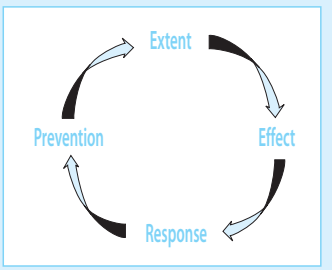
Key conceptual decisions taken at the meeting included the need to incorporate GBV as experienced by both women and men; to interrogate existing administrative data much more closely; to use prevalence studies to determine the extent of under-reporting and rarely reported types such as emotional and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

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

Unique features of the project

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

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



Country context

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

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

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

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

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

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. Mechanisms have been established 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 national action plan is in place to address GBV.
	3. Collect data on violence against women.	3. A progressive legal framework that ensures the protection of women rights is in place.
	4. Sensitise members of the criminal justice system.	4. Police and prosecutors are being trained to address issues of sexual violence.
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 Offence and related Matters) Amended Act, 2007 (Act 32 of 2007); and d) Employment Equity (Act No 55 of 1998).
	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 on violence against women; b) Domestic Violence Programme (prevention and reaction);

[3] Commission on Human Rights, 1996.

Instrument	State responsibility	Progress made
		c) Child Abuse and Neglect programme (prevention and reaction); d) Interdepartmental initiatives to improve Criminal Justice System processes for Rape and Sexual Offences (e.g. Multi Disciplinary Service Centres, specialised training, Sexual Offences Courts, Family Violence, Child Protection and Sexual Offences (FCS) Units); e) Communication, Education and Awareness programmes; and f) Local and community-based programmes (community policing, neighbourhood watches).
SADC Gender and Development Protocol 2008	1. Enacting and enforcing prohibitive legislation.	a) Domestic Violence Act, 1998 (Act 116 of 1998); b) Sexual Offences Act, 1957 (Act 23 of 1957); c) Criminal Law (Sexual Offence and related Matters) Amended Act,2007(Act 32 of 2007); and d) Employment Equity (Act No 55 of 1998).
	2. Eradicating 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. Adopting 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 these 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 which can be used as baseline and to monitor GBV programmes.

The GBV Indicators research implemented by Gender Links is mainly focused on achieving Article 25 relating to adopting integrated approaches with the aim of reducing current 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 uphold citizen's human rights. Further to the commitment of heads of states, the departmental efforts also help tackle gender violence.

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

The Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007 (Act No. 32 of 2007), came into operation on 16 December 2007. It expanded the definition of rape to encompass rape

of men and use of any object in sexually assaulting another person.

Integrated approaches

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

National Council Against Gender-Based Violence (National GBV Council)

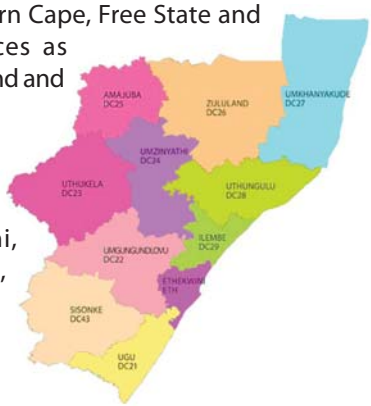
United against rape and gender-based violence, from left, Professor Thirumala Govender, Jes Foordt, Kantharueben Naidoo, Captain Rakesh Premhid, Professor Kolela Mlisana and Sergeant Beverly Mangele.

Photo courtesy of Google Images

Deputy President of the Republic of South Africa Kgalema Motlanthe inaugurated the Council on 10 December 2012 as a direct response to the issues raised at CEDAW following South Africa's country report in 2011. The council comprises government departments, provinces, civil society, NGOs, faith-based organisations, traditional leadership and government agencies. The role of the council is to elevate the multi-sectoral intervention approach to a strategic level and monitor the implementation of all programmes dealing with gender-based violence in the country, including the 365 Days action plan. The National GBV Council advises the ministry, deputy president and deputy chairperson of the council in regards to fulfilling their leadership responsibilities relating to the national response to GBV.

Provincial context

KwaZulu-Natal is located in the south-east of South Africa, bordering the Indian Ocean. It also shares borders with the Eastern Cape, Free State and Mpumalanga provinces as well as Lesotho, Swaziland and Mozambique.



KZN has 11 districts: Ugu, Umgungundlovu, UThukela, Umzinyathi, Amajuba, Zululand, Umkhanyakude, UThungulu, ILembe, Sisonke and Durban Metro.

With a population of 10 267 300, accounting for 19% of the country's total population, KZN has the second largest population after Gauteng province.[4] Black South Africans make up the majority of those in KZN, followed by Indians, whites and the coloured. According to Statistics South Africa's 2011 census, KZN has the highest percentage of the country's Indian population. Largely rural, the province also has South Africa's highest rates of HIV and AIDS. The Ukuthwala culture[5] persists in this province and has been identified as one of the drivers of HIV infection in KZN. Ukuthwala is a form of abduction in which men kidnap a girl or a woman and force the woman's family to endorse marriage negotiations.[6] This is one common form of GBV in the province that is carried out under the guise of culture.

4 www.statssa.gov.za
5 http://www.justice.gov.za/brochure/ukuthwala/ukuthwala.html
6 Ibid.

Previous Research

Intimate partner violence

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

There is evidence that South Africa also has some of the highest levels of physical IPV in the region. More than a quarter (28%) of men participating in the South African Health and Stress Study reported having used physical violence against their current or most recent female partner during their current or most recent marriage or cohabiting relationship (Gupta et al, 2008). Other studies based on male samples found that one in four men had been violent towards a female partner (Jewkes, Sikweyiya, Morrell, et al, 2009; Gupta et al, 2008). One in four women interviewed in the Three Provinces Study reported having experienced physical abuse by a male intimate partner (Jewkes, Levin, & Penn-Kekana, 2003). Dunkle et al (2004a) found that 25.5% of women had experienced physical abuse by an intimate partner in the 12 months preceding the interview and more than half did so in their lifetime.

The Oscar Pistorius case helped shine a light on South Africa's high rate of femicide. *Photo courtesy of Google Images*

The Medical Research Council's *Three Provinces Study* showed gaps in the proportion of women reporting rape to police stations around the country (Jewkes et al, 1999). It found a rate of women "physically forced" into sex as 1300 out of every 100 000 women aged 18-49 years (Jewkes et al, 2001). In the same year, only 210 of every 100 000 women of all ages reported rape to police (SAPS, 1999). These rates show that, at most, one in nine rape cases are reported to police.

Femicide

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

They collected data from mortuary files, autopsy reports and police interviews. Among 1349 perpetrators of intimate femicide, 19% committed suicide within a week of the murder. They found the homicide rate for murders of women to be six times the global average and noted that intimate partners killed half of all women. Suicide after intimate femicide is more likely if the perpetrator is from a white rather than an African racial background. The research also showed that 92 of the deaths of legal gun-owning perpetrators and their victims may have been averted if the perpetrator did not own a legal gun, highlighting the public health impact of gun ownership in cases of intimate femicide-suicide.

Exacerbating factors

GBV is a by-product of gender inequality in South Africa, which remains patriarchal. Underlying factors

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

associated with experience of gender-based violence include male control of women and unequal power and gender relations in intimate relationships (O'Sullivan et al, 2006; Wood et al, 1998; Langen, 2005; Pettifor et al, 2004b; Jewkes et al, 2003; MacPhail & Campbell, 2001, Dunkle, 2004b). Men's control over women is seen as a mark of masculinity. Culture, religion and media reinforce these norms and promote the view that men should be in power within homes and public institutions while women should be in a position of subservience.

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

Effects

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

Gender-based violence and the Victims' Charter

The Commission for Gender Equality (CGE) implemented a study to assess whether police stations and courts possess the necessary capacity to ensure victims of GBV can realise the rights enshrined in the Charter. The study focused on a number of police stations and courts in all nine provinces and a sample of provincial NPA, department of justice and constitutional development and Thuthuzela Centre employees. Implementation of the Victims' Charter is 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; and
- 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 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 a need for increased access to professional services provided by social workers, psychologists and related disciplines in police stations and courts. The study also recommends improving data collection, particularly ensuring data is gender-disaggregated. 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 cooperation among Victims' Charter partners to enable better access to sites and information.

Previous research in KZN

Researchers have conducted a number of GBV studies in KwaZulu-Natal.

Involving the Other Gender: A Case Study of the Men As Partners Program in KwaZulu-Natal, 2007, Rachel Honig

Honig conducted this study in 2007 to assess the Men as Partners (MAP) programme initiatives implemented by Sonke Gender Justice Network in Nkandla and Hope Worldwide in Durban. It sought to establish if working with men can be a solution to ending violence against women or just another meagre attempt to change the unchangeable. The research

included in-depth interviews with project directors, workshops facilitators and community leaders. It also included informal qualitative obtained through interaction with workshop participants.

The study found that MAP had brought about a change in attitudes among the men. However, it found a need to ensure sustainability of these attitudinal changes. This can be accomplished by tackling underlying issues such as poverty and social inequality. The study also discovered an "overreliance on workshops and one-off campaigns" like the "16 Days of Activism." For this reason there is a need to move from once-off events to longer-term interventions. It recommended that, considering perpetrators of GBV remain overwhelmingly male, the national agenda on promoting gender equality should incorporate programmes that challenge patriarchal attitudes.

Prevention in Action (PIA): Lessons Learned and a Model for Social Mobilisation to Address Violence Against Women in South Africa

Project Concern International (PCI), in partnership with the Western Cape Network on Violence Against Women and the KwaZulu-Natal Network on Violence Against Women, implemented a Prevention in Action (PIA) programme in South Africa. The group implemented it in the Khayelitsha sub-district in the Western Cape (WC) and the eThekwini District in KwaZulu-Natal. The PIA programme aimed to reduce the prevalence of physical and sexual violence against women, who had been found to be most vulnerable to HIV infection in both provinces. Researchers undertook a baseline study in 2009. It found that while respondents knew that GBV is wrong, it remained pervasive. Therefore, programme coordi-nators decided to focus on changing another norm -inaction- by encouraging communities to act to prevent GBV. Creative Consulting and Development Works (CC&DW) evaluated the PIA programme using a predominantly qualitative evaluation design, combining it with secondary data for quantitative analysis. It conducted a final study at the end of the four-year programme to understand how it had fostered a better understanding of the strategies needed to prevent GBV.

An analysis of 2429 action narratives documented by the programme over an 18-month period illustrated an understanding of the need for a transition from inaction to action in engaging with GBV.

Surveys conducted in Khayelitsha and Wentworth at the end of the programme provided insight into community perspectives of PIA. Around a third of the participants said that GBV had decreased over the past year as a result of the PIA programme, while another third believed GBV had increased. Overall the programme proved to be effective in addressing and preventing GBV in communities. As such, stakeholders have recommended replicating it in other settings.

Why this research?

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

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

GBV is a serious challenge in South Africa and has profound negative consequences on the health and wellbeing of women and their families, an issue that directly impacts the wellbeing of the country as a whole (Suffla 2004). The study provides important data on the gravity and impact of violence against women in KwaZulu-Natal; information that can be used in the implementation of policies and legislation. The baseline indicators will also help provide data for the monitoring and evaluation activities of the province as the country aims to halve GBV by 2015.

CHAPTER 2
METHODOLOGY

Linda Musariri (far right), Ntombentsha Mbadlanyana (left) and Gloria de Gee, Director Umgeni Community Empowerment Center (UCEC -middle) with *"I" Stories* participants in Pietermaritzburg.
Photo by Gender Links

Key facts

- The KwaZulu-Natal 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 uses 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 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 used administrative data to document the extent of GBV as recorded in the public sector service.

"I (Charity*) had a breakdown when mother died in 2005, I was 13 and I didn't manage it well. I started drinking, clubbing and smoking. My father was never there for me, he denied that I was his daughter. He loved my sister more because she looked like him. I had always been my mother's child so when she died, it was as if my life crushed before me. I started having boyfriends and abusing alcohol. I moved, together with my two siblings and grandmother, to my elder sister place. Things were really fine until 2011 when my sister changed suddenly and started complaining and fighting with us. I got pregnant in 2011 and moved to my boyfriend's place because my sister was nasty.

Life was fine until I gave birth. I started drinking after birth. My boyfriend forced me to do things that I didn't want to do. He used to complain about my drinking and the visits to my family. He used to say I am skinny when having sex. He beat me, even in front of the child. He threatened to kill me saying that if he could not be with me then no one could have me. My mother in law threatened to take away the baby from me when it reached two years. My life revolved around him and his family. I had no say about the child. The family used to call me names and they hated me. It seemed it was a family feud because, my family always fought with his family. My family wondered why I stayed with my boyfriend when he could not even support me.

I went back to my sister's place because things were not going on well with my boyfriend. Life became even harder. My sister stabbed my other sister and her boyfriend and they ended up in the hospital. I did all the house chores at her home but never complained. I didn't eat very much. One day, my sister got cross when she saw me and my boyfriend in her house. She chased us out and told me to go and stay with my boyfriend. She also chased my grandmother and brother out of her house. She even beat me with sjambok. My other sister (the one who was stabbed) called the police and they came and took me to the police station. However, no one helped me there and I had to sleep there with the child. The next day I went to Ester home but was told it was full and had to go to Haven shelter.

At the shelter, it has been hard for me to adjust at first but I am getting there. I am now looking forward to getting a job or go to Cape Town to my other sister, because I can't go back to my sister's place. I don't know where we are with my boyfriend right now. I am not bitter with him even if he comes to his child, I will let him see the child. The two of us get along well but when his family interferes especially his mother, he changes abruptly. It's as if they poison his mind. I can say that the influence from his family triggered the violence.

I have worked before as a sales lady so if I get any job I will be fine. I will have to move to another shelter. It is difficult to get a job without matric. I couldn't finish my matric because my sister introduced me into drinking alcohol and smoking. There was a time I tried to commit suicide because life was unbearable. This was before I got pregnant with my baby."

The account given by Charity highlights the various factors which trigger violence in intimate relationships. Survivor's substance abuse and the negative influence family members promoted physical and emotional abuse. The survivor comes from a family with a weak family structure.

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 through 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 GBV defined GBV as "any act which results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or in private life."[8] It indicated that this definition encompassed, but is not limited to:

- Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;
- Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution; and
- Physical, sexual and psychological violence perpetrated or condoned by the state, wherever it occurs.[9]

For the purposes of this study GBV 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; and
- Sexual harassment.

Project aim

Inspired by the SADC Protocol on Gender and Development, which sets a target to reduce the current levels of GBV by 50% by the year 2015, this study seeks to test the GBV indicators developed through expert consultation and provide extensive data of GBV prevalence in the KwaZulu-Natal province of South Africa. The GBV Indicators Research Study in KwaZulu-Natal Province will contribute to the reduction of GBV by providing data to be used to monitor and evaluate the efforts of government and civil society to halve the current levels of GBV by 2015. The findings from this study 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 gender violence (NAP).

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 KwaZulu-Natal. Specifically, the project aims to:

- Quantify the prevalence of GBV in its different forms and determine the extent of under-reporting; track and report changes;
- Quantify the economic, social and psychological costs of violence;
- Assess the effectiveness of the response by the police, courts, health, social and all related services;
- Assess the way GBV is covered by the media, how this is perceived by audiences and the extent to which the media is playing its role in helping to end or perpetuate gender-based violence;
- Assess the level of political commitment to address GBV;
- Map the underlying attitudes towards gender equality that fuel GBV;
- Assess the effectiveness of prevention campaigns from the point of view of some of the respondents to the prevalence study; and
- Provide pointers for government and civil society in KwaZulu-Natal 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 KwaZulu-Natal?

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

- What is the physical, social, and economic impact of GBV on society?
- What is the response of public services to GBV in KwaZulu-Natal?
- 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 KwaZulu-Natal?
- What is the impact of prevention interventions and mainstream media on GBV in KwaZulu-Natal?

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 KwaZulu-Natal. The project components comprise:

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

Prevalence and Attitudes Household survey

The prevalence and attitudes survey is used to investigate the extent and individual effects of 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. The women's survey described the prevalence and patterns of women's experience of GBV, HIV risk behaviour, pregnancy history, mental health, help-seeking behaviour after experiences of GBV, gender attitudes and exposure to prevention campaigns in KwaZulu-Natal. The men's survey described men's perpetration of GBV gender attitudes, GBV risk behaviour, fathering and exposure to prevention campaigns.

Description of the questionnaire

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

The questionnaire provides information about the following areas:

- A description of gender attitudes, attitudes towards rape and relationship control among women and men;
- A description of the prevalence and patterns of childhood trauma among women and men;
- A description of the experiences of witnessing and intervening with domestic violence among women and men in all countries;
- A description of the risk/protective factors for experiencing GBV among women including socio-demographic characteristics, attitudes, partner characteristics, substance use;
- A description of the prevalence and patterns of women's experience of GBV and associated health risks, including HIV risk factors, condom use, concurrent partners, number of sexual partners and transactional sex;
- A description of the health consequences associated with experience of GBV, including self-reported STIs, HIV testing, unwanted/unplanned pregnancy, substance use, depression and post-traumatic stress disorder among women;
- A description of the prevalence and patterns of men's perpetration of GBV, associated risk factors and health risks;
- Association between gender attitudes, relationship control and perpetration of GBV among men;
- Association between men's perpetration of GBV and HIV risk factors including condom use, concurrent partners, number of sexual partners, substance use and transactional sex;

- A description of the health consequences associated with perpetrating GBV, including STIs, HIV testing, fathering an unplanned pregnancy;
- A description of the awareness of campaigns against GBV and relevant legislation, including the Domestic Violence Act and the Sexual Offences Act;
- An exploration of men's experience of IPV; and
- An exploration of economic abuse and its relationship to GBV.

Sampling

The sampling method is a two stage proportionate stratified design. Firstly, researchers took a random sample of the Primary Sampling Units (PSUs). PSUs form 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 1500:

- 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 group;
- Obtained maps of each of the selected wards from the LMs or through Google Earth;
- Divided each ward into four Enumeration Areas (EAs) depending on the population of the ward (but four for an average ward of 10 000 people - this information is included on the sample);
- Randomly selected one EA in each ward (approximately 400 households in each EA);
- Allocated every second or evenly numbered selected EA for female participants only and allocated every first or oddly numbered selected EA to only male participants;
- Used maps to enumerate the EAs and, if maps did not exist, researchers walked the EA and counted the number of households. They then calculated an interval with the field managers/supervisors to ensure random and stratified sampling to yield 20 interviews in each EA;
- Supervisors then selected a random starting point such as a school, park, cemetery or hospital and marked this on the map; and
- Not allowing for substitution, interviewers endeavoured to complete 20 interviews in each EA.

Inclusion criteria

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

Strengths of the sampling method

This sampling method has several merits, including:

- It ensured that each member of the population had an equal chance of being selected;
- It ensured random selection of the sample, a characteristic which gives the possibility of carrying out further inferences such as standard errors, confidence intervals and hypothesis testing;
- 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; and
- The selection of one person per selected household reduced the risk of contamination of the responses and protection of survivors, which is considered high for such type of surveys involving sensitive questions.

Limitations of the sampling method

The survey sampling methods also presented limitations, such as:

- Some questions applied to only some respondents, for example survivors or perpetrators. The result is that only a small proportion of the sample responded to these; and
- 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 facilitated a training session in June 2011. It focused on project content, orientation, ethics training, understanding methodology and engage-

ment with the questionnaire. The programme also included familiarisation with the questionnaire and training on the Personal Digital Assistants (PDAs) and related activities, adherence to methodology and communication of the deployment schedule. The training sessions included the following:

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

Ethical considerations

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

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.

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

Data collection

The research team conduced community mobilisation in the first week of July 2011. 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. Within each household, the researchers recruited only one randomly-selected eligible person (male or female depending on the EA allocation over the age of 18 years). If researchers did not find the sampled household member at home on the first visit, they made three further attempts to interview the sampled participant. The researchers did not substitute if they could not interview the sampled participant. To ensure safety of respondents, the researchers did not interview men and women from the same households or EA.

Researchers administered the questionnaires using PDAs. An interviewer read each question and associated answer choices as presented on the PDA screen. The participants chose their language of preference. A skip button allowed

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

participants to skip over any question they did not wish to answer. If participants completed the questionnaire without the assistance of the fieldworkers, the fieldworkers remained nearby so they could assist respondents or help answer any questions.

Data management and analysis

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

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

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

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

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

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

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

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

Process

In this KZN project, Esther House, The Haven Shelter and Umgeni Community Empowerment Centre helped GL find the 11 women survivors who participated in the *"I" Stories* workshops.

The three organisations also provided one person each to co-facilitate the workshops together with two GL staff. The facilitators showed participants copies of other "I" Stories published by GL. This helped facilitators build a rapport with participants, allowing them to feel comfortable and understand how their stories would be used. Facilitators gave participants a pseudonym if they felt uncomfortable using their real names. Pseudonyms have been used for "I" Stories throughout this report.

For those participants who understood little English, facilitators helped by translating the consent forms. The participants then completed and signed the consent form. The participants also specified where and how they wanted their story used and whether

their photograph could be used. Participants also voluntarily gave consent to be interviewed in future. Any illiterate survivors received assistance writing their story.

Ethical considerations

The facilitators:

- Informed participants how their stories would be used and distributed;
- Sought permission from the participants to use their photographs and reveal their identities;
- Gave participants the option of using a pseudonym; and
- Required participants to sign off on the final versions of their stories and approve any changes or revisions.

Administrative data

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

Researchers collected and analysed administrative data mainly to complement the results of the prevalence and attitudes survey. It is widely accepted that administrative data does not accurately provide information on the extent of GBV, especially intimate partner violence, mostly due to high levels of underreporting.

Justice Officer Linda Musariri facilitates an "I" Stories workshop in Pietermaritzburg. *Photo by Ntombi Mbadladyana*

Justice Officer Linda Musariri facilitates an *"I" Stories* workshop in Pietermaritzburg.
Photo by Ntombi Mbadladyana

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

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 the areas in need of improvement.[11]

Description of data

Data requested from the respective institutions included:

- Numbers and nature of cases relating to the DVA, SOA 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 had been brought against the alleged perpetrator for the period 2011-2012;
- Number, nature and the treatment required for the GBV cases sent to health centres for the period 2011-2012; and
- Number, nature and type of support provided by identified shelters for the period 2011-2012.

This report analyses the administrative data in conjunction with the results of the household survey to provide some indication on the current levels of underreporting of GBV as well as on the adequacy of the response of public services and their compliance with legislation and policies.

Public pronouncements analysis

Public pronouncements from political leaders have an influence on social behaviour. The words of political leaders carry weight and influence how citizens interact with peers and superiors.[12] Public pronouncements and discourse also contribute to the "creation and/or transformation of the society and culture through rearticulating 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".[13] In this vein, messages passed on by politicians in their speeches have an impact on the way people in their constituencies access knowledge and shape their opinions about GBV and other important social issues. Political discourses analysis can be useful for civil society as a strategic public awareness and accountability tool.

In terms of the indicators project, analysing the speeches and pronouncements of key political figures assists in framing and triangulating the findings of other study components.

Aim

The analysis of available speeches, statements and pronouncements is important to assess how often key senior political figures speak about GBV. In addition, their words help gauge their level of

[10] Walby, S, op cit.
[11] Ibid.
[12] 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
[13] 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

commitment to doing something about it. More specifically, it is important to measure politicians' level of conceptual clarity on the structural causes of the problem and understand whether they offer holistic alternatives for survivors of GBV.

Sources of data

Researchers collected and analysed the content in speeches made by key government functionaries. Researchers undertook desktop research for the purposes of finding speeches online. This included visiting the Government Communication and Information System (GCIS) and all official departmental websites where speeches have been published.

Media monitoring

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

The study sought to answer the research questions outlined below:

- What topics are given the most and least coverage in the media?
- What proportion of coverage is specifically on GBV?
- What proportion of coverage mentioned GBV?
- How do media houses in each country compare with each other in their coverage of GBV?
- Of the coverage on GBV, what proportion is on prevention, the effects on victims and others, support and response?
- How do the VAW topics further break down into sub-topics?
- What is the overall breakdown of genres (news and briefs, cartoons, images and graphics, editorial opinion, features, analysis, feedback, interviews, profiles and human interest)?
- How does VAW coverage break down with regard to these genres?
- Where do the stories come from (international, regional, national, provincial, and local)?
- How does VAW coverage break down with regard to origin of stories?
- On average, how many sources does each GBV story have?
- On average, how many stories indicate the connection between GBV and HIV and AIDS?
- Overall, what is the proportion of women and men sources?

A South African trader sells newspapers. Newspapers, one of the most important places for citizens to access information on preventing GBV.
Photo by Trevor Davies

- 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?

Tarisai Nyamweda media monitoring. *Photo by Sikhonzile Ndlovu*

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 pre-designed database. 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 data into the database;
- Quality control by GL;
- Delivery of the database by email to GL to be synthesised into one central database that has made possible this regional overview report, as well as country comparisons with regional averages; and
- Data analysis and generation of graphs.

Qualitative research

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

- How are women and men labelled as sources in the media?
- Is there a good balance of men and women sources? Do women and men speak on the same topics, or do media reserve specific topics for men only and specific topics for women?
- Does the language promote stereotypes of men and women?
- Are physical attributes used to describe women more than men?

- How are women portrayed in the story? How are men portrayed in the story?
- Are all men and women in a society represented and given a voice in the media?
- What are the missing voices, perspectives in the story?
- What are the missing stories?

Table 2.1: 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 to answer the key questions relating to extent, effect, response, support and prevention. The flagship tool is the prevalence and attitude 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 remain underreported. The *"I" Stories* put a human face on all aspects of the research. The administrative data and media monitoring provide key insights in relevant areas. Triangulation helps to verify and strengthen the findings, as well as provide important insights for policy-making and action planning.

CHAPTER 3
EXTENT OF GBV

Yes we can! A banner at a Diakonia Centre in Durban, South Africa. *Photo by Trevor Davies*

Key facts

Lifetime prevalence

- Thirty-seven percent of women interviewed experienced GBV, while 43% of men perpetrated GBV, at least once in their lifetime.
- The highest proportion of violence experienced by women and perpetrated by men is IPV.
- Emotional IPV is the most commonly experienced and perpetrated form of IPV, while physical IPV is the second most common.
- Twenty-four percent of women experienced, while 29% of men perpetrated, physical IPV in their lifetime.
- Twelve percent of women experienced, while 14% of men perpetrated, sexual IPV in their lifetime.
- Eighteen percent of women experienced abuse during pregnancy.
- Four percent of women had been raped by non-partners in their lifetime, whereas 12% of men reported raping a non-partner in their lifetime.
- Five percent of women have been sexually harassed in the workplace.
- Underreporting of IPV and rape to the police and medical providers by women in a big problem.
- Five percent of women who experienced physical IPV reported it to police.

Past 12 month prevalence

- Sixteen percent of women experienced, while 22% of men reported perpetration of, some form of IPV in the 12 months prior to the survey.
- Physical IPV is the most common form of IPV experienced by women.
- Eleven percent of women experienced physical IPV and 10% experienced emotional abuse.

"I (Zandile) grew up in a polygamous family. My father's first wife had her own homestead and children with my father. I had three half sisters and two half brothers. My father used to drink a lot of alcohol. He didn't provide for us but spent all his money with the senior wife. We used to struggle at home without food to eat. We got help from the neighbours.

I had three blood siblings but all of them passed away. I'm the only one who is still alive. I was about seven years old in 1987 when we were involved in a car accident while coming from a ceremony hosted by the first wife. My mother had a miscarriage and stayed in hospital for a while. My aunt came from Durban to help out and stayed with us until my mother passed away in December of 1988. My aunt took me to live with her in Durban.

I lived with a large extended family. I fell pregnant with my first child in 1997 and my aunt chased me away from home. I went to live in Pietermaritzburg with my other aunt. After giving birth, I went back to school. I received a pay out of R14 000 from my deceased father's estate with which I bought a small homestead for myself.

I met Mlilo in 2001; the man who would be the father of my children. He was unemployed and I had occasional jobs. He managed to change the ownership of my plot to his name without my knowledge. I only realised that he had changed ownership of the house when I decided to sell it. When I confronted him about this, he said I was overreacting and that as the man, the house was meant to be in his name.

We continued living together and had more children. During this time he started having extramarital affairs and slept with the women in our house. He also started abusing me and hitting me. Eventually, in 2009, he sold the house without informing me. At about that time, my third child died. Despite all this, I kept staying with him and I fell pregnant again. Again, he sold the new place we were staying in and bought a car without telling me. He was not working but made money through selling my personal items. He was cruel and abusive and used to swear at us all the time.

I moved out but he came after me and asked me to come back and stay with him, to which I agreed. We stayed with his other children from another woman. One day he got upset and pointed a gun at us, threatening to kill us. We called the police, who came and arrested him for keeping an unlicensed weapon. He was taken to the police, but he was released. Even after this incident he occasionally swore at us saying he was tired of us. He also threatened to kill me and the children.

I got afraid and decided to ask for help from the social workers. The social worker recommended that I go with my children to stay at a shelter.

Today, he does not know where I am with the children. My children and I are safe now. I am happy to be far away from this abusive relationship and this cruel man who wanted to kill us."

Zandile's account highlights how women who face various forms of childhood abuse are more likely to be abused as adults. A survivor of intimate partner violence, Zandile was subjected to emotional, physical and economic abuse. Her partner demonstrated patriarchal attributes when he changed the title deeds of her house because he felt entitled to do so as a man. Zandile finds support and protection from domestic violence at a shelter.

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 a family, including battering, dowry-related violence and marital rape. GBV also includes non-spousal violence and violence related to exploitation and 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 (Amnesty International Report, 1995, p 8). This study measures 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 699 women and 595 men from different demographic and socio-economic backgrounds from across the province. GL 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	51.3	358	52.5	311
30-44	30.4	212	26.8	159
45+	18.3	128	20.7	123
Total	100	698	100	593
Level of education				
High school incomplete and lower	51.5	360	52.5	311
High school complete	48.5	339	47.5	281
Total	100	699	100	592
Race				
Black African	96.3	673	97.3	575
Coloured	1.4	10	1.3	7
Indian	2.3	16	1.0	6
White	0	0	0.3	1
Other	0	0	0.3	2
Total	100	699	100	591
Have you worked to earn money in the last 12 months				
No	70.1	490	48.56	286
Yes	29.9	209	51.4	303
Total	100	699	100	589
How much did you earn before tax and including benefits				
1-500R	10.7	21	3.1	9
501-1000R	17.4	34	13.8	40
1001-2000R	33.2	65	27.0	78
2001-5000R	21.9	43	45.7	132
5001-10 000R	13.3	26	9.3	27
10 000-20 000	3.6	7	1.0	3
Total	100	196	100	289
Ever in an intimate relationship				
No	16.2	113	17.0	101
Yes	83.8	586	83.0	494
Total	100	699	100	595
Ever had sex				
No	17.0	116	9.4	54
Yes	83.0	565	90.6	522
Total	100	681	100	576

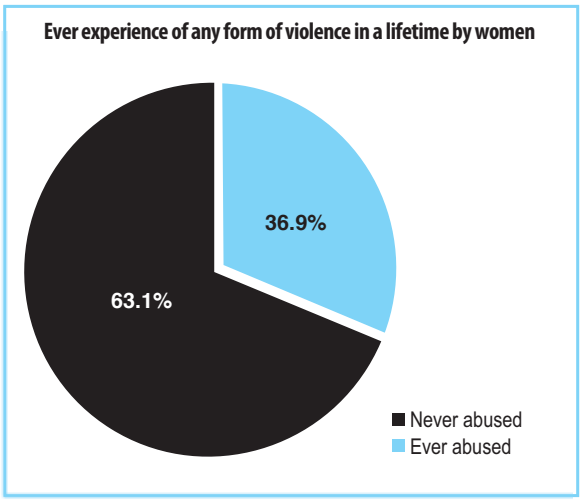
Table 3.1 shows that youths form the majority of participants in this study sample. The majority are black with 96% black women and 97% black men. Less than 50% of women and men had completed high school. Only 30% of women and 51% of men had been employed in the 12 months before the survey. Four in every five women (83%) and men interviewed (91%) had been in a heterosexual relationship.

GBV in a lifetime

GBV, specifically violence against women, is common in South Africa (Jewkes 2001). Violence against women is widespread in societies that promote male dominancy and is usually considered as a private family matter, which leads to underreporting (Heise 2002).

The current study examines the extent and nature of GBV in KwaZulu-Natal province. Researchers used two separate questionnaires in the prevalence and attitudes survey to determine lifetime experiences of GBV by women aged 18 and older and perpetration of GBV by men of similar ages. This study measured both the lifetime prevalence of GBV and prevalence in the 12 months prior to the survey. Researchers ascertained the lifetime prevalence by noting whether the 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



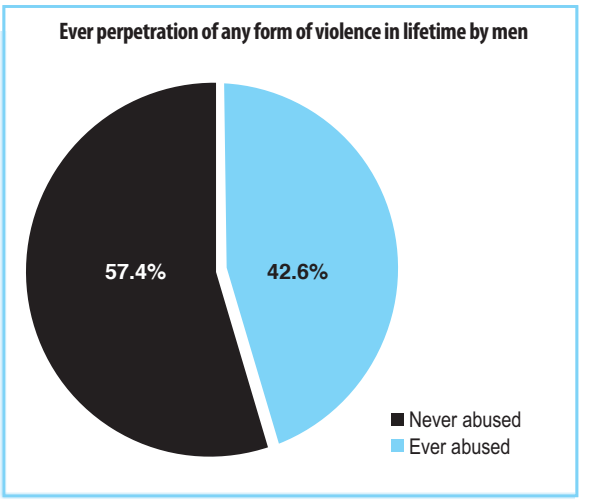


Figure 3.1 illustrates that 37% of women reported experience of some form of GBV in their lifetime, while 43% of men reported ever perpetrating violence against a woman. This measure of GBV includes any form of violence occurring within intimate partner relationships and sexual violence outside intimate partner violence. This finding is indicative of the high levels of lifetime experience of GBV among women in the province.

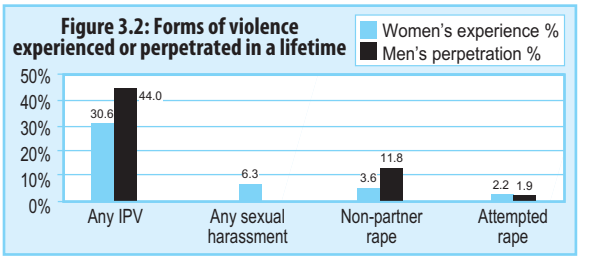


Figure 3.2 shows that the most common form of GBV experienced by women and perpetrated by men is intimate partner violence. Nearly one in every two men (44%) who had ever been in an intimate relationship reported perpetrating violence against an intimate partner. Three in every 10 (31%) women who had ever been in an intimate partner relationship reported experiencing intimate partner violence.

Women also reported GBV experience at the hands of non-partners. This included sexual harassment, non-partner rape and attempted and completed rape. Six percent of women interviewed experienced sexual harassment either at school, in the workplace, at a traditional healer or while using public transport.

One in 25 women (4%) had been raped by a non-partner. A greater proportion of men reported perpetrating rape. About one in eight (12%) men reported ever raping a non-partner. This implies that women underreport their experiences of sexual abuse by non-partners.

Intimate Partner Violence

The term "intimate partner violence" describes physical, economical or psychological harm by a current or former partner or spouse. Researchers asked currently, or previously, partnered women a series of questions about whether they had ever experienced specific violent acts and, if so, whether this had happened in the 12 months preceding the survey.

There are four main types of intimate partner violence (Saltzman et al. 2002):

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

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

Psychological/emotional violence involves trauma to the victim caused by acts, threats of acts, or coercive tactics. Psychological/emotional abuse can include, but is not limited to, humiliating the victim, controlling what the victim can and cannot do, withholding information from the victim, deliberately doing something to make the victim feel diminished or embarrassed, isolating the victim from friends and family.[14]

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

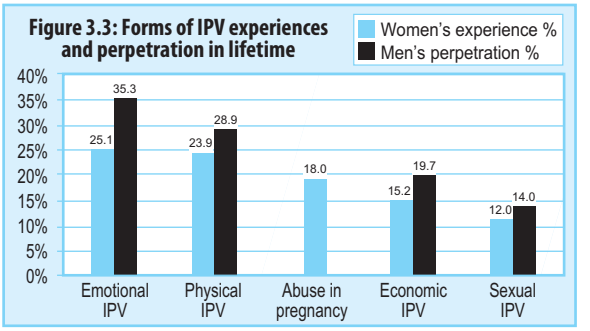


Figure 3.3 shows that the most common form of IPV experienced by women and perpetrated by men is emotional violence. Twenty-five percent of women experienced and 35% of men perpetrated emotional

[14] Saltzman et al 2002.

violence. Physical abuse is the second most common form of abuse experienced by women. Abuse in pregnancy is also common, with 18% of women having been abused by their partners during a pregnancy. The least reported form of IPV experienced by women and perpetrated by men is sexual IPV. More men than women reported sexual abuse. This may imply underreporting of sexual violence, especially when rigid social norms support the sexual entitlement of men in intimate relationships (Jewkes 2001).

Emotional IPV

This survey assessed emotional abuse via six questions about experience (or perpetration) of a series of different acts that include controlling, frightening, intimidating or undermining women's self-esteem. Researchers asked women participants if a male partner had ever insulted them or made them feel bad; belittled or humiliated them in front of other people; threatened to hurt them; stopped them from seeing friends; done things to scare or intimidate them; or boasted about or brought home girl-friends. Researchers asked men if they had done any of these things to a female partner.

Twenty-three percent of women told researchers they had experienced emotional IPV, while 36% of men perpetrated emotional IPV. Acts of emotional violence include being insulted, threatened, humiliated, stopped from seeing friends and boasting about girlfriends.

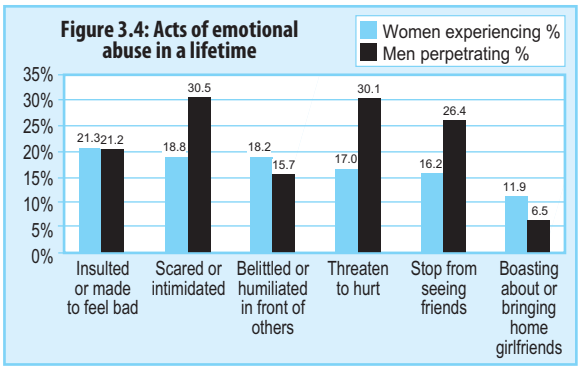


Figure 3.4 illustrates that the most commonly reported acts of emotional violence by women is being insulted or made to feel bad; being scared or intimidated and being humiliated in front of others. Twenty-one percent of women had been insulted, 19% had been intimidated or made to feel afraid and 18% had been humiliated in front of others. Twelve percent of women experienced an intimate partner boasting about or bringing home girlfriends while 16% had been prevented from seeing friends.

The most commonly reported acts of emotional violence reported by men include intimidation, threatening to hurt and stopping a partner from seeing friends. Thirty-one percent of men had intimidated a partner, while 30% had threatened to hurt a partner and 16% had humiliated a partner in front of others. Twenty-six percent of men admitted to stopping a partner from seeing her friends.

Nolwazi, like many women, have experienced physical abuse from a partner. *"If I fought with him he would take out his knife and threaten me with it. One day he came again trying to hit me, I ducked and ran away... he came after me, he caught up with me and took me back to his room, strangled me until I was out of breath. He saw that I was not moving or doing anything and he let go and tried to wake me up."*

For all acts - except boasting about girlfriends, humiliation in from of others and being insulted - the proportion of men admitting to perpetration is higher than the proportion of women reporting experience.

Acts of emotional IPV from "I" Stories

The GL *"I" Stories* show that emotional abuse remains prevalent among women in South Africa. Women said they had been subjected to verbal abuse such as swearing and name calling with the intention to belittle them. Some complained that they had been forced to do things they did not want to do. In one case, a woman reported that her husband had extramarital affairs and brought other women home with him.

Physical IPV

Researchers assessed physical IPV by asking five questions about whether women had been slapped, had something thrown at them, had been pushed or

shoved, kicked, hit, dragged, choked, beaten, burned or threatened with a weapon. Similarly, the survey asked men if they had inflicted any of these acts on an intimate partner.

Physical IPV is the second most common form of IPV. One in five (21%) women experienced, while three in every ten (30%) men, perpetrated physical IPV.

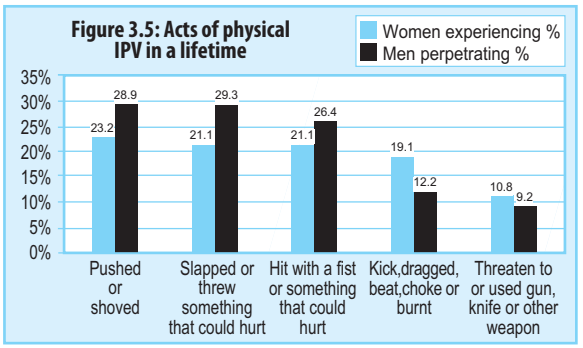


Figure 3.5 shows that the most common acts of physical IPV experienced by women is pushing, shoving, slapping and hitting. About one in four women (23%) had been pushed while 21% had been slapped or hit. Similarly, these acts had also been most commonly reported by male perpetrators. Twenty-nine percent of men admitted to slapping and throwing dangerous objects, 29% had pushed or shoved and 26% had hit a partner with a fist or dangerous object. Although the use of weapons appears least common, it is noteworthy that almost one in every 10 (9%) men who had ever been in an intimate relationship had threatened to hurt a partner with a weapon.

The study sought to explore the frequency of occurrence of the various acts of violence experienced or perpetrated. Researchers therefore differentiated between once off incidents and multiple incidents.

Table 3.2 shows that seven per cent of women had been physically abused once in their lifetime whereas 16% experienced this on multiple occasions. This implies that a woman who has experienced physical abuse once faces a higher risk of repeated abuse. Meanwhile, 15% of men admitted perpetrating physical IPV on one occasion. This is twice as much as the proportion of women who admitted experiencing physical abuse once in their lifetime. This suggests that under-reporting of abuse is common. This may be due to societal norms that in many ways condone intimate partner violence. Some women interpret physical violence as a sign of love. Others believe they've been beaten because they deserve it because of something they've done (Strebel, 2006). Fourteen percent of men reported perpetrating physical IPV more than once in their lifetime.

Table 3.2: Frequency of physical IPV

Frequency	Women's experience %	Men's perpetration %
Never	76.5	71.1
Once	7.3	14.7
More than once	16.1	14.2

Acts of physical IPV from the "I" Stories

Researchers found that physical IPV is the most common form of violence among those women who gave their personal accounts of GBV experiences. The women's stories illustrate recurring acts of physical abuse. Other forms of IPV in the "I" stories included threats to kill partner using a weapon (knife or gun). Some men use the excuse of tradition as a reason for beating their wives, referring to the abuse as a form of punishment, expression of anger or as a means of gaining and asserting power (Abrahams, 2005).

Zandile said: *"I received a pay-out from my deceased father's estate. I received R14 000 that was shared between me and my siblings. I bought a small homestead for myself. He managed to change the ownership of my plot to his name when without my knowledge. I only realised that he had changed ownership of the house when I decided to sell the house. When I confronted him about this, he said I was overreacting and that as the man, the house was meant to be in his name."*

Economic IPV

Economic or financial abuse takes many forms, including controlling the finances, withholding money or credit cards, giving a partner an allowance,

making a partner account for every penny spent, stealing or taking money from a partner, exploiting a partner's assets for personal gain, with-holding basic necessities (food, clothes, medications, shelter), preventing a partner from working or choosing a career, or sabotaging a partner's job by making them miss work.[15]

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

Economic IPV is the third most prevalent form of IPV experienced by women and perpetrated by men. Fifteen percent of women experienced, while 20% of men perpetrated, some act of economic IPV in their lifetime.

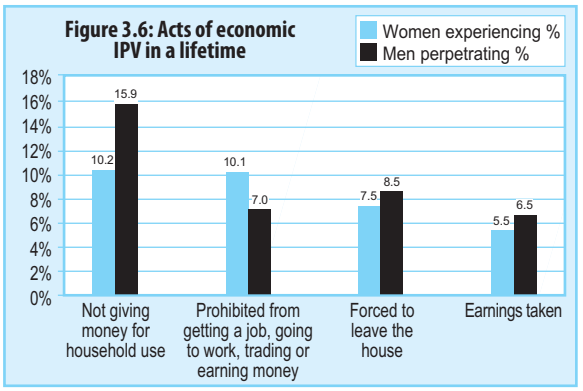


Figure 3.6 shows that the most common form of economic IPV experienced by women and perpetrated by men is the withholding of money for household use. Ten percent of women experienced this while 16% of men admitted to doing it. Ten percent of women had been prohibited from earning an income while seven percent of men admitted to perpetrating such an act against a partner. Eight percent of women had been forced to leave the house while nine percent of men forced a partner and their children to leave the house. Six percent of women had their earnings taken and seven percent of men took a partner's earnings.

Acts of economic IPV from the "I" Stories

A minority of "I" Stories participants reported experiencing economic IPV. The most common form of economic IPV involved women whose partners had taken their valuable personal items such as jewellery, money and in one case the deed to a home. In one instance, a woman's husband sold her home without her knowledge, insisting that he had the right to do that as a man and as head of the household. This illustrates the traditional values that continue to be upheld in South Africa's patriarchal society, a society in which many men wield greater control and power than women and feel entitled to do as they please (Strebel 2006). Traditional gender roles expect women to be submissive to men, thus the above survivor's partner felt that she challenged his role as decision-maker when she confronted him about selling the house. Another form of economic IPV occurs when a woman's partner refuses to take care of his family. While it is essential to promote economic empowerment of women as a strategy to curb violence against women (Kim 2007), it is also important to first promote changes of such attitude and behaviour that remain common among men.

Sexual IPV

Nolwazi experienced sexual IPV and said: *"At night he would touch me and have sex by force, when I screamed he would turn up the volume on the radio so that nobody would hear me. If I fought with him he would take out his knife and threaten me with it. After the fight in the morning he would apologise and do a special thing for me, trying to make up for what he did, he would tell me that it was not his fault and I should not disagree with him when he wants sex I should always give in to him, because I am his girl now."*

Sexual violence[16] is non-consensual completed or attempted contact between the penis and the vulva

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

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 study assessed sexual IPV experienced by women using three questions. These covered: if their current or previous husband or boyfriend had ever physically forced them to have sex when they did not want to; whether they had had sex with him because they had been afraid of what he might do and whether they had been forced to do something sexual that they found degrading or humiliating. Twelve percent of women experienced, while 14% of men perpetrated, sexual IPV in their lifetime.

Table 3.3: Frequency of sexual IPV

Frequency	Women's experience %	Men's perpetration %
Never	88.3	86.0
Once	2.4	7.3
More than once	9.3	6.7

The proportion of women admitting experiencing sexual IPV once in their lifetime is lower than the proportion of men admitting such an offence. Two percent of women experienced and seven percent of men perpetrated sexual abuse. This may imply that women do not fully disclose sexual abuse in intimate relationships. This may be because women feel ashamed or see such experiences as normal (Jewkes 2001). Women may normalise sexual violence in their relationships due to fear that any form of resistance may result in serious consequences, such as physical abuse (Wood 1997).

Karabo suffered abuse during pregnancy: *"He would force me to sleep with him and as result I fell pregnant. Even when I had told him that I was pregnant he still continued to force me to sleep with him. I went to the hospital to go to the antenatal clinic and I did an HIV test and it came out positive. I started taking my ARV treatment. He started swearing at me and beating me up, asking where I got the disease from. He called me names and told me that I am mad. It continued until I gave birth and beyond."*

Nine percent of women and seven percent of men reported experiencing and perpetrating sexual IPV more than once, respectively, in their lifetime.

Acts of sexual IPV from the "I" Stories

In line with patriarchal norms, the male partners of some of the survivors felt entitled to sex whenever they wanted it. Several male partners forced sex on the survivor when she did not want. The negative health consequences of forced sex reported in the *"I" Stories* included unintended pregnancy.

Abuse in pregnancy

Intimate partner violence may be prompted or intensified by pregnancy. Abuse in pregnancy can be due to a longstanding abusive relationship that continues after a woman becomes pregnant. It may also commence for various other 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. Researchers asked women if they experienced acts of abuse during any of their pregnancies.

Figure 3.7: Acts of abuse in pregnancy

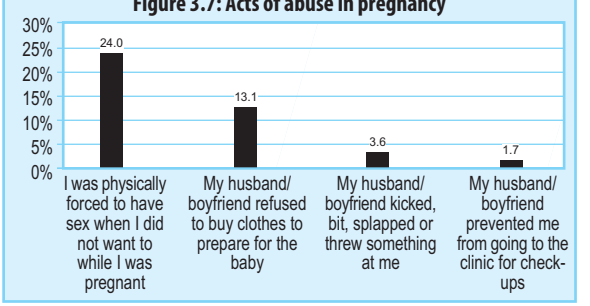


Figure 3.7 shows that the most common act of abuse experienced by pregnant women is being physically forced to have sex when they do not want to. Twenty-four percent of women had been physically forced to have sex against their will during pregnancy. Thirteen percent of women said a partner refused to buy clothes to prepare for the baby. Four percent of women had been physically abused by a partner and two percent had been prevented from making ante-natal visits.

Non-partner rape

This study assessed rape of women by men other than a partner by asking three questions. Researchers asked women if they had been forced or persuaded to have sex against their will by a man who was not a husband or boyfriend. They also asked whether a woman had been forced by a man to have sex when she'd been too intoxicated to stop him. Finally researchers asked women if they'd been forced or persuaded to have sex with more than one man at the same time. The latter is an indicator of gang rape.

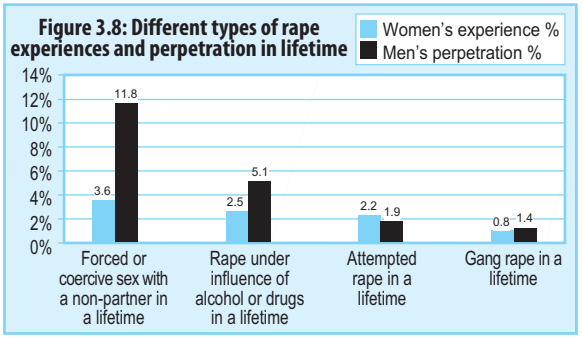


Figure 3.8 shows that the most common act of rape experienced by women is forced non-partner rape. Four percent of women had been raped by non-partners while 12% of men admitted perpetrating non-partner rape. The discrepancy in the proportion of rape experiences among women and perpetration among men implies underreporting of non-partner rape by women. Three percent of the women experienced, and five percent men perpetrated, rape under the influence of alcohol or drugs. Two percent of women experienced attempted rape and one percent reported that they had been gang raped.

Frequency of non-partner rape

Researchers framed questions about rape so that the respondent could provide 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

Any non-partner in a lifetime	Women's experience %	Men's perpetration %
Never	96.9	88.2
Once	1.7	6.2
More than once	1.4	5.6

Table 3.4 shows that two percent of women had experienced more than one incident of rape while six percent of men had raped a non-partner more than once. The proportion of once off incidents is, however, greater than the proportion of multiple incidents among women. Two percent of women experienced, while six percent of men perpetrated, non- partner rape. This implies that women do not always report non-partner rape.

Sexual harassment

According to the SADC Protocol on Gender and Development, sexual harassment means any unwelcome sexual advance, request for sexual favour, verbal or physical conduct or gesture of a sexual nature, or any other behaviour of a sexual nature that might reasonably be expected or be perceived to cause offence or humiliation to another whether or not such sexual advance or request arises out of unequal power relations. The prevalence of sexual harassment of women suggests men feel entitled to sex even outside intimate relationships (Jewkes 2006).

Researchers asked women if they had experienced sexual harassment in the workplace, schools, whilst using public transport, or when seeking help from traditional or religious leaders.

Figure 3.9: Sexual harassment experiences by women in lifetime

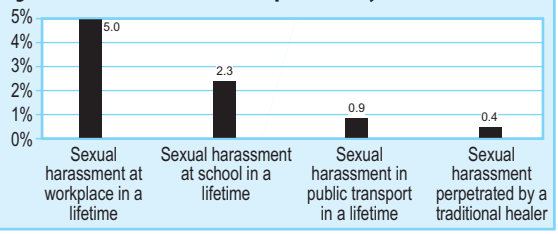


Figure 3.9 shows that the most common experience of sexual harassment occurs in the workplace. Five percent of women who had ever worked experienced some form of sexual harassment in the workplace. Two percent of women said they'd been harassed at school and one percent of women had experienced sexual harassment on public transport. The proportion of sexual harassment perpetrated by a traditional healer is less than one percent (0.4%). These findings provide evidence for the need to enforce punitive measures for sexual harassment offenders.

Extent of reporting GBV in a lifetime

It is assumed that women do not disclose or report GBV for various reasons, including being ashamed, not wanting to speak badly about a partner in public and also because they view the abusive situation as normal and/or a private issue (Jewkes 2001). Reporting violence, especially in intimate partner relationships, places women at even higher risk of repeated abuse since it may be taken as resistance to male dominance (Woods 1997). Societal norms which expect women to be tolerant to violence support all these reasons.

In the study, researchers asked women who reported experience of physical IPV and rape in their lifetime whether they reported the incident to the police or to a health facility.

Table 3.5: Extent of reporting GBV in lifetime

Criteria	%
Proportion of women who had been physically abused and reported abuse or threats to police in lifetime.	4.8
Proportion of all women, who had been physically abused, injured and who sought medical attention in lifetime.	3.9
Proportion of all women who had been raped and reported incident to police in lifetime.	0.8
Proportion of all women who had been raped and sought medical attention in lifetime.	0.5

Table 3.5 shows that five percent of women had been physically abused by intimate partner at some point in their lifetime had reported the abuse or threats to the police. Four percent of women who had been physically abused sought medical attention. About one percent of women who had been raped reported it to police and health care professionals. These results show that there is extensive underreporting of various forms of abuse. This may reflect women's distrust of police and medical practitioners. Women may feel they will not be able to receive adequate and effective help from these outlets. Societal norms which silence and disempower women while normalising sexual entitlement in men can also be seen as reasons for underreporting (Jewkes 2010; Strebel 2006). There is a need for in-depth research on factors hindering women from reporting violence.

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

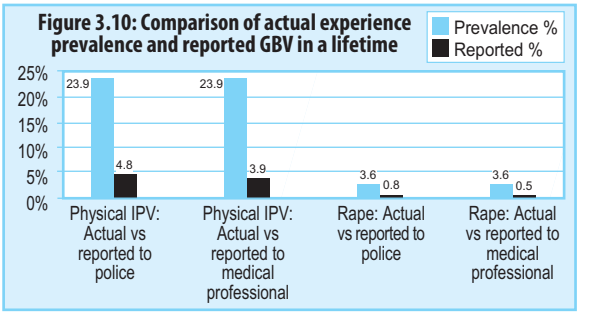


Figure 3.10 illustrates that the proportion of women reporting to the police and the medical providers is lower than the proportion of women who had been either physically abused or raped. This implies underreporting of physical IPV and non-partner rape both to police and to health care facilities. Figure 3.10 shows that 24% of women had been physically abused by a partner but just 5% of women who had been physically abused reported the abuse to the police. One in 25 women (4%) who had been physically abused by a partner sought medical attention for their injuries. Four percent of the women admitted experiencing non- partner rape in their lifetime, though only one percent of these women reported the incident to the police. A lesser proportion (0.5%) of women sought medical attention. The underreporting makes it difficult to derive accurate estimates of the extent of IPV and rape in South African society. However, the existing estimates indicate the gravity of violence against women (Suffla 2004). In a society with a long history of violence, resistance to violence through reporting to law enforcement agencies may result in worse consequences (Woods 1997). This calls for a need to raise awareness among women on the importance of reporting violence to the police and medical professionals. There is also a need to ensure that the police and health professional offer adequate protection and help to the survivors of violence.

GBV in past 12 months

Researchers asked women and men whether their experiences, or perpetration, of GBV had occurred in the 12 months prior to the survey.

Figure 3.11: Experience or perpetration of GBV in past 12 months

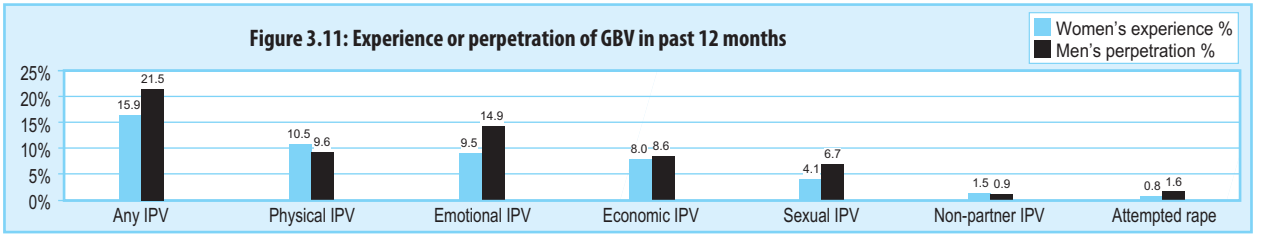


Figure 3.11 shows that 16% of women experienced, while 22% of men perpetrated, IPV in the 12 months prior to the survey. Physical IPV is the most prevalent form of GBV in the 12 months before the survey. Eleven percent of women experienced it, while 10% of men reported perpetration. The second most common is emotional IPV and the least common is sexual IPV. For all forms of IPV, except physical IPV, a greater proportion of men reported perpetration compared to the proportion of women who reported experience. Two percent of women had been raped by a non-partner and one percent of men had raped a non-partner in the 12 months before the survey. Two percent of men had attempted to rape in a similar period.

Extent of reporting GBV in past 12 months

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

Table 3.6: Extent of reporting GBV in past 12 months	
Criteria	**%**
Proportion of ever partnered women who had been physically abused and who reported abuse or threats to police in past 12 months.	4.8
Proportion of ever partnered women who had been physically abused by partners, injured and sought medical attention in past 12 months.	3.0
Proportion of all women who had been raped and who reported to police in past 12 months.	0.02
Proportion of all women who had been raped and sought medical attention in past 12 months.	0.1

Table 3.6 shows that 5% of women who had been physically abused reported the abuse to the police while 3% sought medical attention in the 12 months before the survey. Less than 1% of women had been raped and reported to police or a healthcare facility in a similar period. There is a need for intensive research on the reasons why women are not reporting to the police or seeking medical help after experiencing physical abuse and rape.

Once again, a comparison of the proportion of women who experienced physical IPV or rape and the proportion who reported it shows a high level of underreporting.

Figure 3.12: Comparison of actual experience prevalence and reported physical IPV in past 12 months

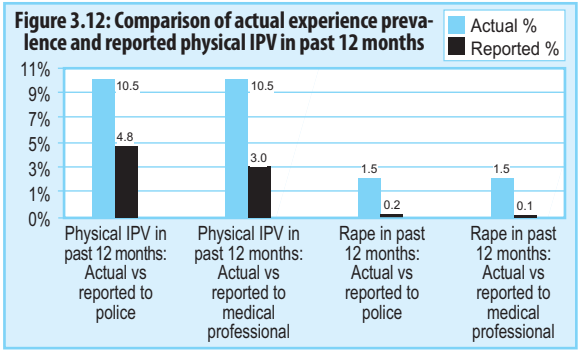
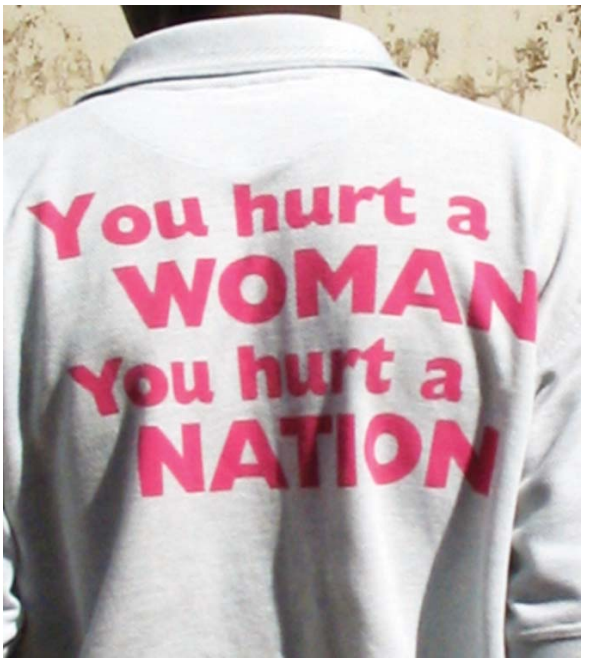


Figure 3.12 shows that 5% of women who experienced physical IPV in the 12 months before the survey reported it to police whereas just 3% of these women sought medical help for injuries. Researchers found it is less likely for women who had been raped by non-partners to report to either police or health care facilities. Less than 1% reported to the police or sought medical attention.

A comparison of lifetime reporting and 12-month reporting shows that a greater proportion of women reported physical IPV in lifetime experiences. In contrast, the extent of current reporting of rape is lower than the lifetime extent of reporting. Research found it is more common for women to report physical IPV and rape to medical facilities than to police, both in lifetime experience and in the 12 months prior to the survey.



Conclusion

The chapter provides evidence that GBV is a widespread social problem within South Africa's KZN province. Both the reports of women and men from a representative sample attest to this. The statistics show a high prevalence of IPV that features predominantly within the private sphere. The most common form is emotional, which has much to do with men's socialisation to control and dominate women in a patriarchal society. Sexual IPV is also reported and this illustrates women's ongoing limitations when it comes to negotiating sexual engagement with their partners.

This chapter also highlighted a trend of under-reporting of violence which means services women have not been utilising services such as health care facilities and police. Women, however, reported that they have been more likely to seek medical help for injuries sustained. There is a need to further research barriers to accessing GBV services.

CHAPTER 4
DRIVERS OF GBV

Violence against women is a crime - everyone has a right to safety and security. *Photo by Gender Links*

Key facts

- Women of all ages, levels of education and employment status are vulnerable to IPV.
- Age is associated with lifetime IPV perpetration, with men aged 45 and older having the highest proportion of perpetration.
- Prevalence of IPV perpetration by men in a lifetime increased significantly with an increase in age.
- A significantly higher proportion of men who did not matriculate had raped or abused an intimate partner.
- A significantly higher proportion of women who worked 12 months prior to the survey had been raped.
- A significantly higher proportion of men who drink alcohol or use drugs perpetrated IPV in the 12 months prior the survey.
- A significantly higher proportion of men who had been abused as children perpetrate IPV.
- The prevalence of IPV perpetration is highest among men who drink alcohol regularly.
- A significantly higher proportion of men who had been victims of child neglect and physical abuse had abused a partner.
- A significantly higher proportion of men who had been sexually abused and neglected in their childhood admitted to committing non-partner rape compared to men who did not experience such abuse in childhood.
- GBV is exacerbated by patriarchal values which promote male dominance in the home.
- Political leaders can do more to address GBV through public discourse.

"When I (Zanele) was in Grade one or two, my father would handcuff and beat us kids up with a sjambok. He used to beat us up especially if we did not answer him back. He once beat up me and my sister because he suspected that we had been sleeping with boys. He beat us up until we confessed though it was not true. My sister's face was cut open by the sjambok. When he took us to the clinic, he told us to lie to the nurse and say that my sister had fallen and cut her face when we were playing in a junk yard. He also beat my crippled grandmother for standing up to him and defending us.

I also remember another instance he returned home drunk and told us to take off his shoes and clothing as he lay on the bed. On the day he beat us up because he suspected that we were sleeping with boys, he told me to go down on my knees and then he pointed the gun to my head. He told me to pray. I was young, stupid and didn't know what to pray for so I just kept quiet. He pulled the trigger but the gun never went off. He pulled it again and it never went off again. He prohibited us from going to school until the marks from the beatings on our bodies had disappeared. However, we ran away to a neighbour's house and asked for food and a place to sleep. We ate from the bins, sometimes. Eventually, social workers took us away from him to the Natal Children's Home.

Finally, we had a roof over our head, food and brothers and sisters. We went to a good school but my father would still come and fetch us for weekends and holidays. He would still beat us up during that time. We would go back to the home with marks and we would show the caretakers but they never did anything about it. It troubled me why they did not do anything. I eventually ran away from the home and stayed with a boyfriend.

The relationship started off very well; however he started being abusive to me. He reminded me of my father and the abusive life that I wanted to get away from. I couldn't leave him because I was pregnant and didn't have anywhere else to go.

I gave birth and went back home but my father chased me. So I went back to my boyfriend and the abuse continued. I fell pregnant again. The abuse carried on until he stabbed me on my shoulder. I had to carry the baby and do the washing with a painful arm and he never helped me.

He continued to emotionally and physically abuse me. In December 2012, I went back home to my father but spent Christmas at my sister's place. My father was not nice to me and my children. One day he accused me of not wanting to be married and said I didn't have a job.

He said, "I should have killed you and your sister when you were young because you are good for nothing." He would swear at me using words that I had never heard and that hurt me. He also said I'm only good at sleeping with boys and getting babies.

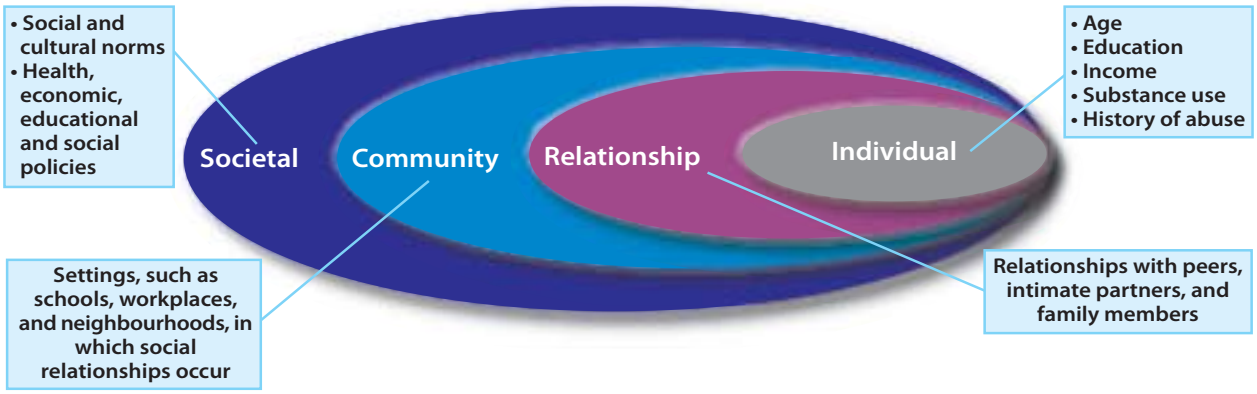
One day I heard my stepmother telling my father that I was HIV positive and should leave their house. I confronted them about this but my father told me to leave the house that night. I slept at a neighbour's home. I went back the next morning to apologise to my father again but he chased me away with a sjambok. I had nowhere to stay because my other relatives did not want to have anything to do with me and my children."

Zanele's story provides an example of women who suffer violence from childhood through to adulthood. Her lack of economic empowerment, lack of family support and her family's history of violence increase her vulnerability to GBV. Her story also shows a troubling lack of support from social institutions in a society which perceives violence as normal. Her father and relatives blame her for the IPV she experiences and refuse to help her.

GBV is a complex problem influenced by a multitude of factors (Suffla 2006). This chapter explores individual, family, relationship, community and societal factors that increase the likelihood that a man will abuse his partner, as shown by the ecological model framework.[17]

[17] The socio-ecological model: a framework for violence prevention. http://www.cdc.gov/violenceprevention/pdf/sem_framewrk-a.pdf

Figure 4.1: The ecological model of factors associated with VAW



The ecological model in Figure 4.1 is a theoretical framework that explains why some violence occurs, why some men are more violent than others and why some women are consistently the survivors of abuse (Heise 2002). Understanding the reasons for, and the factors associated with, experience or perpetration of gender violence is a precursor in the design of gender violence prevention interventions. This study investigated the association between the experience and perpetration of violence looking at individual, family, community and societal characteristics of participants. It also explored social norms around gender relations as well as the association between gender-based violence and individual level factors.

Individual level influences comprise personal factors that increase the likelihood of becoming a victim or perpetrator (Heise 2002). Examples include socio-demographic factors, attitudes and beliefs that support IPV, isolation, and a family history of violence.

Socio demographic factors

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

Table 4.1: Socio-demographic 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	30.0	0.3	36.3	0.03	13.8	0.8	22.1	0.6
30-44	37.5		48.8		18.4		22.9	
45+	24.6		51.5		15.1		17.3	
Level of education								
High school incomplete and lower	29.3	0.7	53.7	0.0007	14.4	0.7	24.5	0.1
High school complete and over	32.5		32.4		18.0		17.0	
Worked in past 12 months								
No	29.0	0.4	44.8	0.7	16.4	0.8	19.9	0.5
Yes	34.0		43.3		14.9		22	

Age

Table 4.1 shows that the prevalence of IPV perpetration in a lifetime increased significantly with an increase in age. There is a significant difference in perpetration of IPV among men, with the highest proportion of perpetration among men aged 45 and older. The difference in IPV experience prevalence is not statistically significant among women of all ages in lifetime experiences and in the 12 months prior to the study. This implies that women all of ages remain equally vulnerable to IPV.

Education level

A significantly higher proportion of men who did not complete matric perpetrated IPV in their lifetime compared to men who had ($p<0.05$). More than half of the men (54%) who did not complete high school perpetrated IPV in their lifetime, while 32% of men who completed high school had perpetrated IPV. The differences in the prevalence of IPV experience according to level of education among women in lifetime and in the 12 months prior to the survey are not statistically significant.

Research has shown that women who are empowered educationally and economically are less likely to experience IPV (Jewkes 2002). However, in a society where violence in intimate relationships is considered normal, all women despite level of empowerment remain vulnerable to IPV. This finding underscores the need to create an environment of intolerance toward violence against women. This can be done through educational campaigns which inform members of society about the rights of women and also encourage men not to use violence to define their manhood in intimate relationships (Jewkes 2006).

The survey found that men who have been formally educated are less likely to perpetrate intimate partner violence. *Photo by Nomthi Mankazana*

Employment status

There is no significant difference in the proportion of women who experienced, or men who perpetrated, IPV according to employment status in the 12 months before the survey ($p>0.05$). This implies that both the employed and unemployed remain almost equally vulnerable to abuse.

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	5.5	0.3	9.9	0.6	1.2	0.4	1.5	0.1
30-44	3.9		12.2		0.8		0.6	
45+	2.2		15.3		2.4		0.0	
Level of education								
High school incomplete and lower	3.9	0.6	16.4	0.04	2.1	0.2	1.4	0.2
High school complete and over	3.0		6.6		0.6		0.3	
Worked in past 12 months								
No	3.8	0.8	7.9	0.6	0.6	0.05	0.7	0.6
Yes	3.1		15.3		3.6		1.1	

Age

Table 4.2 shows that there is no statistically significant difference in the proportions of women who had been raped in the different age groups (p=0.3) in lifetime experiences and in the 12 months prior the study (p=4). Similarly, there is no statistically significant difference in the proportion of rape perpetrators in the different age groups (p=0.6) in lifetime experiences. This finding is also consistent for rape perpetration in the 12 months before the survey (p=0.1).

Education

While there is no significant difference in the proportion of women that had been raped according to education category (p=0.6), a higher proportion (16%) of men who did not complete matric had raped compared to those who had completed matric (7%).

Employment status

A significantly higher proportion of women who worked in the 12 months prior to the survey had been raped (p=0.05). Four percent of working women, compared to 1% of women who had not worked, had been raped in the 12 months before the survey.

Alcohol and substance abuse

South Africa is said to have the highest level of consumption per drinker in the world (Jewkes 2010). This study looked at the links between alcohol and substance abuse and GBV. Questions relating to alcohol and drugs included whether the respondent had taken alcohol in the 12 months prior to the survey. If the participant responded yes to this question, researchers asked them how often they drank. Researchers also asked participants whether their current or most recent partner consumed alcohol and how often. Questions on substance use included whether the respondent or their partner used drugs and how often.

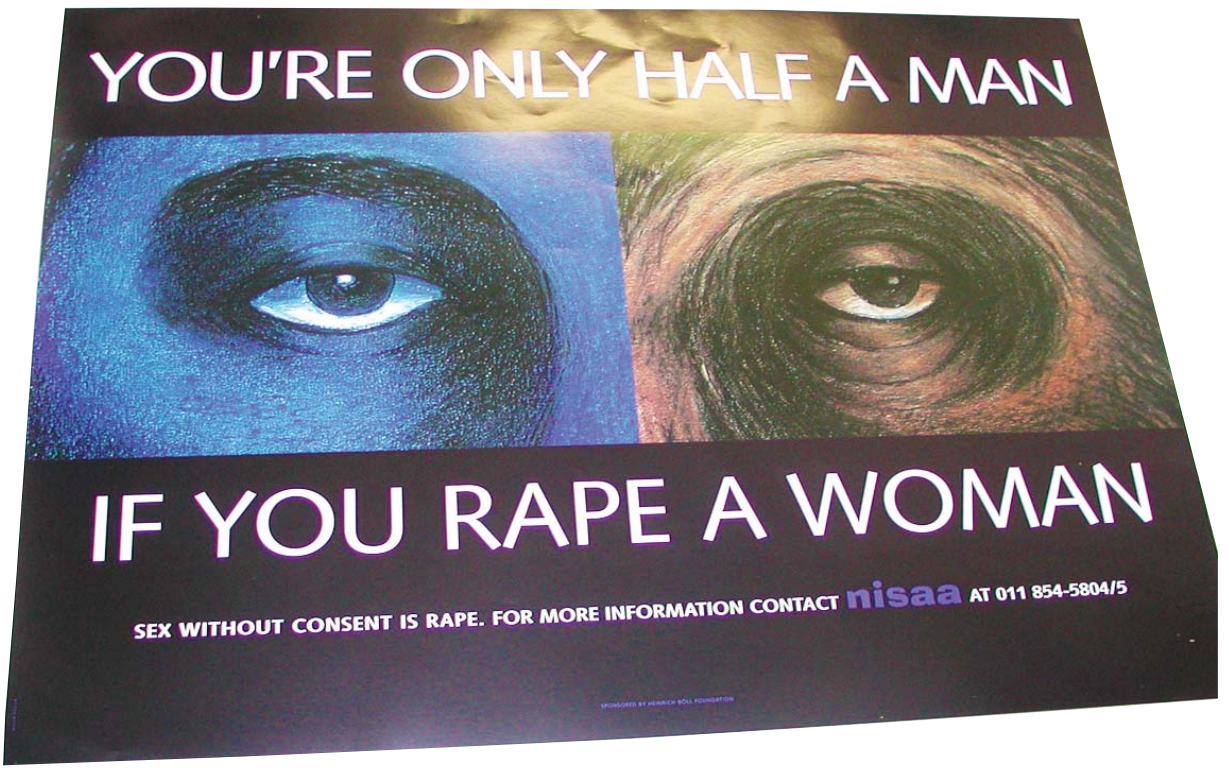


Table 4.3: Alcohol and drug consumption patterns by women and men		
	% women	% men
Have you consumed alcohol in past 12 months		
No	84.2	58.2
Yes	15.8	41.8
How often do you take a drink containing alcohol		
Monthly or less	42.0	39.8
2-4 times a month	24.2	25.8
2-4 times a week	27.8	16.3
4+ times a week	6.0	18.1
More than five drinks on one occasion		
Never	30.1	3.9
Less than monthly	34.1	36.8
Monthly	11.4	26.3
Weekly	22.7	27.6
Daily or almost daily	1.7	5.4
Current partner alcohol frequency		
Every day/nearly every day	6.2	0.5
Only at weekends	12.4	4.3
A few times in a month	13.0	3.2
Less than once a month	2.2	5.8
Never drank	66.0	86.0
Stopped drinking	0.2	0.2
Current or most recent partner drug use		
No	94.6	96.3
Yes	5.4	3.7

Table 4.3 shows that more men than women consumed alcohol in the 12 months before the study. Forty-two percent of men compared to 16% women consumed alcohol in the 12 months prior to the study. A higher proportion of men said they binge drink (96%) and drink more than five alcoholic drinks on one occasion. One in 20 men told researchers they regularly binge drink and consume more than five alcoholic drinks on a daily basis. On a weekly basis, 28% men compared to 23% women consumed more than five drinks on one occasion. Nearly one in eight (12%) women had partners who consumed alcohol only on weekends, whereas 6% of women had a partner who consumed alcohol every day or nearly every day. Five percent of women and 4% of men had intimate partners who use drugs. These findings on alcohol and drug consumption illustrate regular and high consumption levels by both men and women.

"... He would come back every Friday around midnight smelling of alcohol. He would want sex and if I refused he would make up a story so that he would hit me for not sleeping with him."
This excerpt is a recount of how a perpetrator abused his partner while under the influence of alcohol.

Strong links have been found between IPV and alcohol and drug use (Jewkes 2002; WHO 2006).

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 consumed alcohol	25.8	0.09
Partner did not consume alcohol	12.7	
Partner used drugs	27.8	0.3
Partner did not use drugs	16.4	

The results in Table 4.4 show that the difference in the prevalence of IPV experience among women whose partners consumed or did not drink alcohol is not statistically significant (p=0.09). There is also no significant difference in the prevalence of IPV experience between women whose partners used drugs and women whose partners did not (p=0.3).

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	29.5	0.002
Did not drink alcohol	13.5	
Used drugs	34.4	0.005
Did not use drugs	16.2	

Boys participate in a Take Back the Night March. *Photo by Trevor Davies*

A significantly higher proportion of men who consumed alcohol or drugs perpetrated IPV in the 12 months before the survey (p<0.05). Thirty percent of men who drank alcohol, and 14% of men who did not drink alcohol, perpetrated IPV in the 12 months before the survey. About one in three (34%) male drug users and 16% of non-drug users committed IPV in the 12 months prior to the survey. The difference is statistically significant (p<0.05).

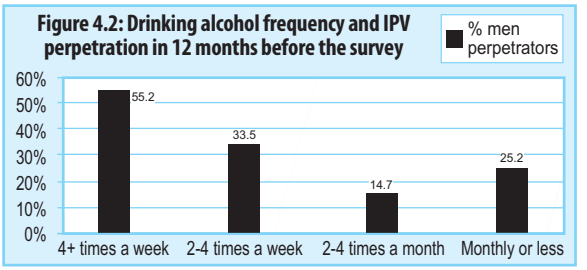


Figure 4.2 illustrates that the prevalence of IPV perpetration is highest among men who regularly consume alcohol four or more times per week. While the rate of IPV increases significantly with alcohol consumption (Jewkes 2002), men who had the least frequent alcohol consumption (monthly or less) are more likely to commit IPV than men who drank two to four times per month.

The qualitative study found that alcohol and drugs can be identified as drivers of IPV perpetration. In one narrative, a participant recounted how a partner had physically and sexually abused her every time he came home drunk.

Child abuse

Researchers asked participants about experiences of childhood neglect and abuse. Researchers ascertained child abuse through a series of questions about forced sex, unwanted sexual touching and being severely beaten leaving marks and neglect by family, teachers or other community members. This study explores three forms of child abuse: physical abuse, neglect and sexual abuse.

This research defines child physical abuse as a person ever experiencing an incident such as being beaten with a whip and left with a bruise or mark. This could have occurred at home, school or in the community. Child neglect included not being given enough food, parents being too drunk to care for their children, or children spending time outside the home without any adults to supervise them.

To ascertain experiences of child sexual abuse, researchers asked participants whether they had ever been touched sexually or forced to touch someone, whether they had sex with someone of the opposite sex who had been more than five years older, or whether they had been forced to have sex before they turned 18.

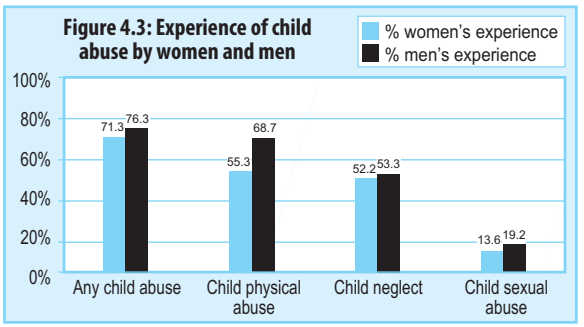


Figure 4.3 illustrates that a majority of participants in this study experienced child physical abuse. However, the proportion of men (76%) reporting child abuse experiences is greater than the proportion of women (71%). More men than women admitted experiencing all three different forms of abuse in their childhood. Physical abuse is the most common form of child abuse experienced by women and men, whilst the least common is sexual abuse. Fifty-five percent of women and 69% of men experienced physical abuse in childhood. More than half of women (52%) and men (53%) said they had been neglected as children. Thirteen percent of women and 19% of men told researchers they'd been sexually abused as children. These findings call for child abuse prevention strategies with a special focus on young boys who have not typically been perceived to be at increased risk of all forms of child abuse.

Child abuse as a risk factor for IPV perpetration

Experiences of abuse throughout life have an impact on whether a person will be violent or tolerate violence. In men, child abuse increases the risk of perpetrating IPV in adulthood (Abrahams 2006; Jewkes 2006). This study explored the link between child abuse experience by men and perpetration of IPV in lifetime using chi square tests of association.

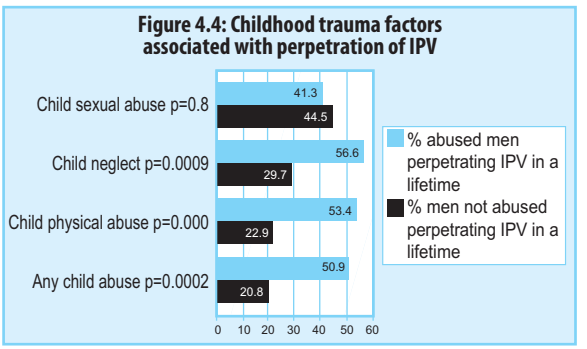


Figure 4.4 shows that a significantly higher proportion of men who had been victims of child neglect and physical abuse perpetrated IPV compared to those who had not been abused as children ($p<0.05$). More than half (53%) of men who had been physically abused as boys perpetrated IPV at least once in their lifetime, while 23% of men who had never been physical abused perpetrated IPV at least once in their lifetime. Fifty-seven percent of boys who had been neglected, compared to 30% of boys who had not been neglected, perpetrated IPV.

These findings align with previous research on perpetrators, showing that childhood trauma negatively influences the developmental processes in boys (Jewkes 2006). Violence is normalised as a solution in certain circumstances. While girls learn to tolerate violence, boys learn to use it (Jewkes 2002). As a result, men who have been abused in childhood are at an increased risk of being perpetrators of violence.

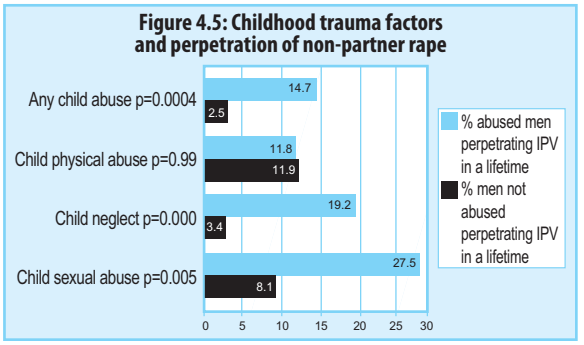


Figure 4.5 shows that there is a significant difference in prevalence of rape perpetration among men who experienced any form of child abuse and those who did not. Fifteen percent of men who perpetrated non-partner rape experienced some form of child abuse whereas three percent of men who perpetrated non-partner rape did not experience such trauma in their childhood. There is no significant difference in prevalence of rape perpetration among men who had or had not been physically abused as children. The results also show that a significantly higher proportion of men who had been victims of child neglect and sexual abuse are more likely to commit non-partner rape when compared to men who had not been abused as children ($p<0.05$).

This is consistent with previous research showing that violence is a learned behaviour as men who have been abused in childhood are more likely to perpetrate abuse (Abrahams 1999, Jewkes 2002). These results show that abuse is a vicious circle which is most likely to continue unless the relevant stakeholders implement measures to stop it. Thus greater effort should be made to tackle the problem of child abuse. Survivors of child abuse also need appropriate support systems to enable them to heal from the experiences of abuse. For men, trauma may result in feelings of inadequacy, anger and an exaggerated need to control women to assert their manhood (Jewkes 2006).

Gender relations

Gender attitudes that support and enshrine male supremacy tend to promote and normalise GBV towards women (Abrahams 2006; Jewkes 2002). These attitudes promote violent behaviour as a means of control and to legitimise male authority. Thus women who challenge male dominance or undermine male authority in the home are at increased 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 have been empowered (Strebel 2006).

This study explored the individual attitudes and perceptions of men and women about their communities' attitudes towards gender relations.

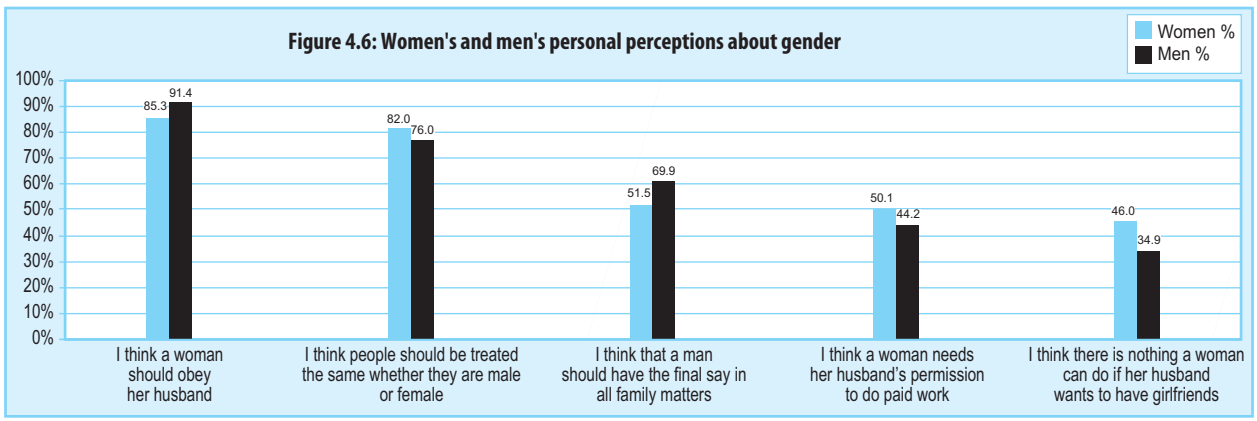
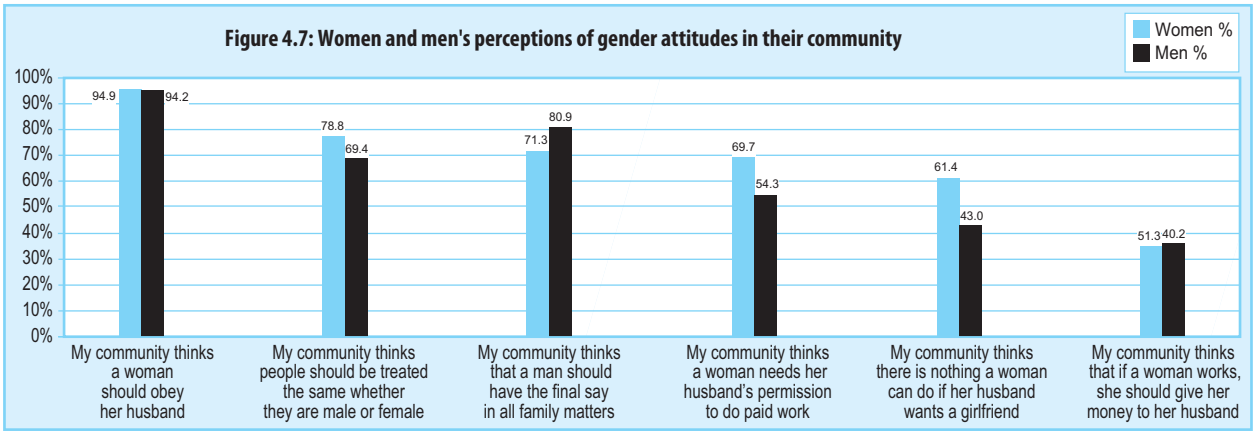


Figure 4.6 shows the individual attitudes towards gender relations of men and women. Generally, the results show that GBV is exacerbated by patriarchal values which promote male dominance in the home. More men than women agreed that a woman should obey her husband (91%) and that a man has the final say in all family matters (70%). Men who hold such conservative views about the social status of women are more likely to commit IPV (Jewkes 2002). The majority (85%) and nearly half (52%) of the women affirmed that a woman should obey her husband and that a man has the final say in all family matters, respectively. Additionally, half of the women agreed that a woman need's her husband's permission to do paid work.



The results in Figure 4.7 comprise perceptions that the individuals who took part in the study have of the views held by members of their community. The community perceptions of male dominance appear more established than the attitudes of study participants. Ninety-five percent of women and 94% of men felt that their community believed that a woman should obey her husband. Thus, it is not surprising that a relatively high proportion of women (61%) perceive that a woman is powerless if her husband wants to have girlfriends. More women (79%) than men (69%) perceived that their communities supported equality between women and men.

Sexual entitlement in marriage and legitimacy of violence

In the Zulu custom, the concept of isoka reinforces patriarchal and misogynistic attitudes; it gives men the right to show dominance in sexual relations and entitlement to use violence as a means of control or punishment for women (Jewkes 2010, Strebel 2006). The notion of equating payment of *lobola* with purchasing property and wife "ownership" also impacts sexual relations and the manner in which sex is negotiated between partners.

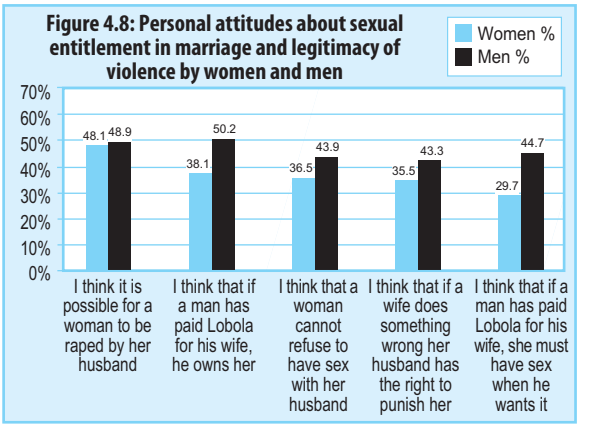


Figure 4.8 shows the individual perception of men and women on sexual entitlement and legitimacy of violence. More men (45%) than women (30%) perceive

that a man can have sex when he wants and cannot be refused sex if he paid lobola. Forty-three percent of men and 36% of women believe that a husband has the right to punish his wife. This implies that a number of people in KZN still look at certain aspects of IPV as normal. Nearly half of the women (48%) agreed that a woman cannot be raped by her husband. This again implies that women have learned to tolerate certain violent behaviour such as sexual abuse as normal and legitimate in intimate relationships.

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

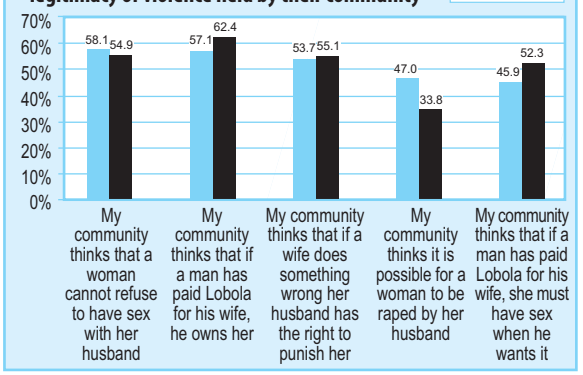


Figure 4.9 shows the perceptions that individuals in the study have of the views held in their community about sexual entitlement in marriage and legitimacy of violence. The community perceptions of male dominance also appear well established, in some cases more so than the individual attitudes. Thirty-four percent of men and 47% of women believe that their community feels it is possible for a woman to be raped by her husband. Sixty-two per cent of the men said their community believes a husband owns his wife if he paid lobola. These results imply that men continue to exercise power over women due to a socially-constructed masculine identity. More women than men perceived that members of their community feel a woman cannot refuse to have sex with her husband. This implies women perceive their communities to hold conservative views about, and tolerant towards, women's sexual abuse in intimate relationships.

Political Discourse

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 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.

Figure 4.10: GBV mentions in political discourse

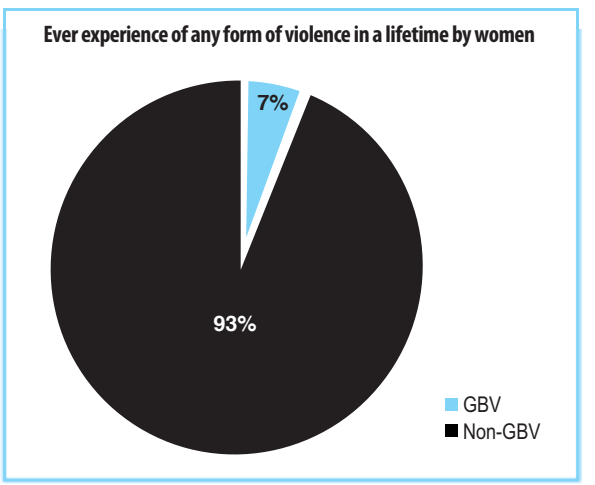


Figure 4.10 illustrates that of the 2238 political speeches collected from April 2010 to March 2011, only 7% made reference to gender-based violence. This indicates that politicians have given scant attention to the important issue of gender-based violence. By speaking more frequently about GBV, the country's political leadership could play a highly effective role in sensitising society to this social ill.

Figure 4.11 GBV mentioned as main topic

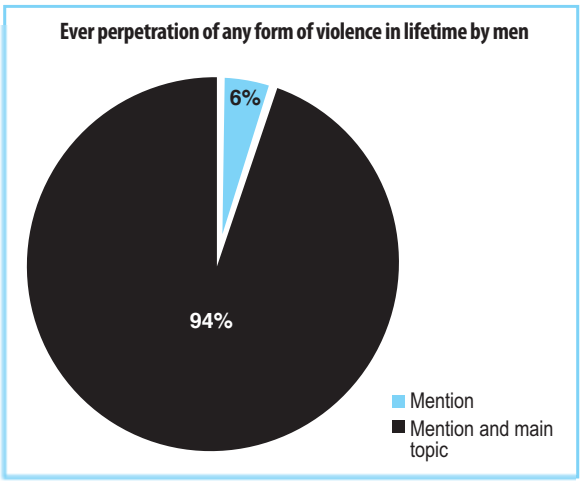


Figure 4.11 shows that an analysis of the 154 speeches which referred in some way to GBV, only 6% addressed gender violence as a main topic. This indicates that an overwhelming majority of those speeches that include GBV incorporate mention of it only as a passing reference. This illustrates that South 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. Former KwaZulu-Natal Premier Zweli Mkhize made one such passing reference in the royal household budget speech of 2010/11. In it he called the monarch a "tireless campaigner for respect for women's rights and their emancipation, fighting for domestic violence, abuse of women," but failed to provide any substantial information about gender violence.

Monarch as champion for development:

Isilo samaBandla has spent most of the year implementing a programme to support the programme of our government, making appearances in many functions in support of various Members of the executive and increasing the appeal and uptake of the programmes of service delivery. On these occasions of public engagements, Isilo has persistently acted as:

- The champion of peace, reconciliation and unity of all our people and advising strongly against the destruction of statues and symbols of past governments and leaders and calling on these to be embraced as our common heritage;
- An advocate for socio-economic development, including provision of infrastructure - roads, water, electricity, etc;
- Promoter of the creation of sustainable livelihoods with people being an integral part of the fight to eradication of poverty, talking strongly against dependence and indolence;
- As a champion for the building of schools and provision of quality education;
- As a strong ally in the fight against crime;
- Campaigner against corruption especially by those entrusted with high government official responsibility;
- Advocate for socially responsible conduct, speaking strongly against drunkenness substance abuse (drug and alcohol);
- Tireless campaigner for respect for women's rights and their emancipation, fighting against domestic violence, abuse of women;
- Champion for provision for support and protection for orphans and vulnerable groups in society - an aspect that the whole Royal Household is playing a significant role in the nearby and remote communities.

Adapted from the budget vote of the Office of the Premier, delivered by the honourable Zweli Mkhize, former premier of the province of KwaZulu-Natal

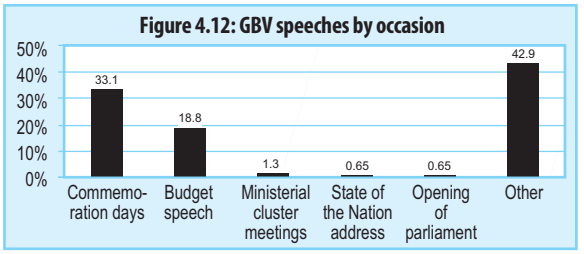


Figure 4.12 illustrates that most political speeches that mention GBV (43%) fall in the "other occasion" category. This includes the release of the National Crime statistics, the launch of various services and victim empowerment events. This seems to indicate that politicians address GBV throughout the 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 account for about a third (33%) of all speeches. Nearly one in five speeches (18%) 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 mentioned GBV in 9% of speeches while the president addressed GBV in 7% of speeches. This is a clear indication that while 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, 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 is 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 MP's in 36% of speeches. It is worth noting that politicians only addressed community members in 15% of all speeches, about two of every 10 speeches. These findings show that political leaders mainly address other politicians in their speeches, underscoring a need for leaders to better target general citizens in order to create meaningful awareness of gender violence in society.

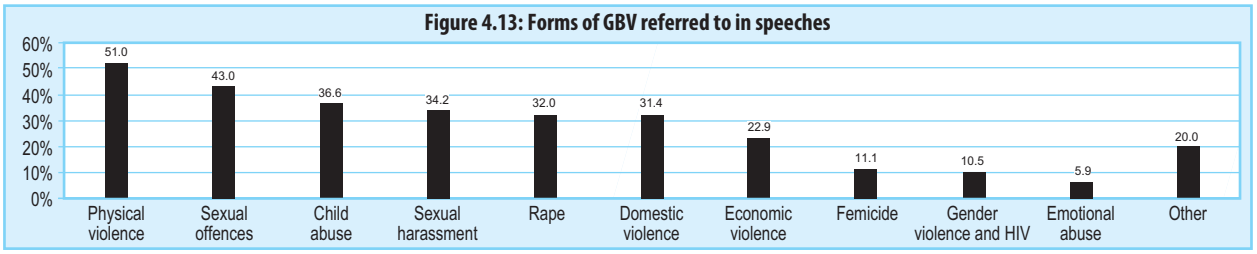


Figure 4.13 shows that politicians mentioned physical violence most commonly as a form of gender violence - in half (51%) of all speeches. Politicians mentioned sexual offences and child abuse in 43% and 37% of speeches, respectively. Less mentioned forms of GBV include femicide (11%), the link between 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

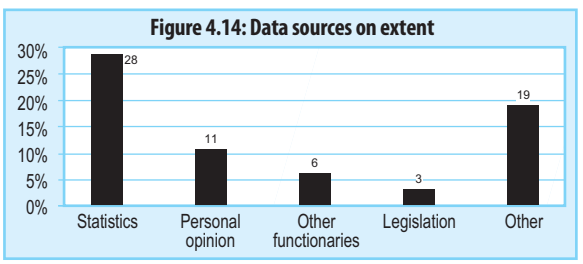
men killed in abusive relationships, political leaders can raise awareness about many less reported forms of GBV. For example TW Mchunu, MEC for Transport Community Safety and Liaison, noted that "Gays, lesbians and prostitutes are amongst the most vulnerable groups... sexually, emotionally and physically abused because of their different lifestyle."

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 on all forms of GBV, except those which fall under the "other" category, as well as 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

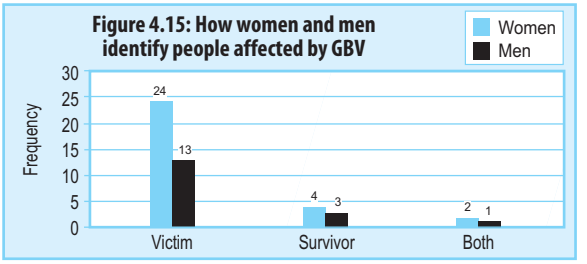
Only 28% of speeches made reference to the extent of GBV. Furthermore, women spoke more (38%) about the extent of GBV compared to men (16%). This shows that political leaders have so far failed to provide scope on gender violence, thus making it difficult to fully understand and contextualise the prevalence or even existence of GBV. KwaZulu-Natal Health MEC Sibongiseni Dhlomo made reference to GBV's extent by mentioning that: "During 2008/09 a total of 10 423 new sexual assaults were reported in Public Health facilities with 3604 receiving antiretroviral prophylaxis."



According to Figure 4.14, in 28 speeches politicians used statistics as the data source on the extent of GBV. Politicians used their own opinion as a source in 11 speeches, while mentioning 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 mentioned: "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 service providers.

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 is 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.



Nearly a quarter speeches (24%) referred to people affected by gender violence as "victims" while the speakers used the term "survivor" less frequently, in just 5% of speeches. Figure 4.15 shows that women

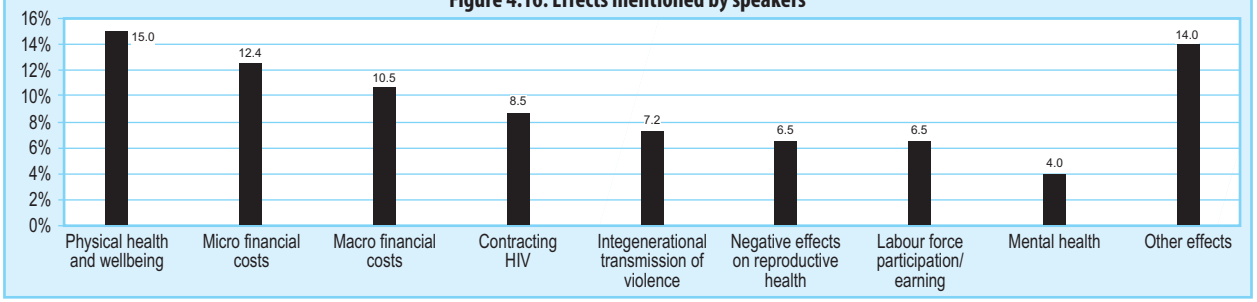
spoke more of victims than men - 24 occurrences compared to 13 - and women also mentioned survivors more, in four speeches compared to three by men. At the debate on National Women's Day, MP Connie Zikalala mentioned that "women remain victims of domestic violence and abuse." By using the term survivor, the speaker highlights agency and the ability of an affected person to move on from an abusive relationship. In contrast, a victim is not yet removed from their place of pain.

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).

Figure 4.16: Effects mentioned by speakers



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 survivors of gender violence can be impacted by the experience. According to Figure 4.16, the most frequently noted effects of GBV related to physical health and wellbeing, mentioned in 15% of speeches.

Angie Motshekga mentioned such effects at the closing ceremony of regional Women's Month, noting that "a mother was grievously assaulted with a spade by her husband and admitted 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, intergenerational 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.

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, with five mentions. At Budget Vote 7, MP Pat Lebenya-Ntanzi noted that "The new department of women, children and people with disabilities has only been allocated 156 million over a three year period to achieve its goals." The provincial premier mentioned financial resources in one speech while the state president, provincial MECs and deputy president did not mention financial resources at all.

Figure 4.17: How often did politicians mention prevention methods?

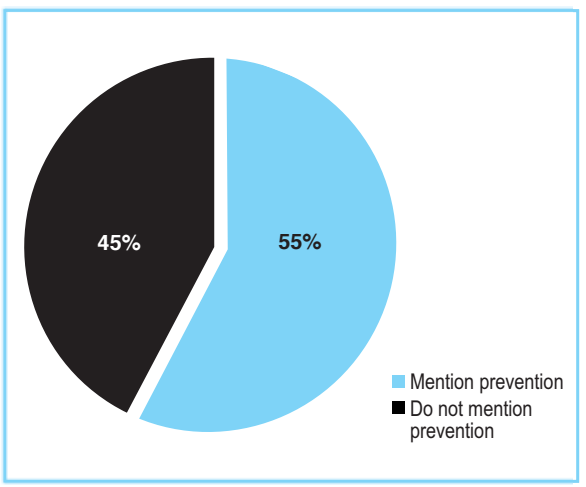


Figure 4.17 shows that politicians mentioned prevention measures in more than half (55%) of speeches, with legislative measures most frequently cited in 40% of speeches. KwaZulu-Natal MEC for Health Sibongiseni Dhlomo mentioned that South Africa has "introduced key legislation to protect the rights of children, including the Domestic Violence Act, the Child Justice Act and the Sexual Offences Act." Politicians mentioned campaigns and protests to end gender violence in 33% and 27% of speeches, respectively. Fewer mentioned prevention measures including cyber dialogues on GBV, media coverage and inclusion of GBV in 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.

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. KwaZulu-Natal MEC of transport community safety and liaison said: "We also need to take into serious consideration the cultures and/or customs that are demeaning and belittling... [especially] *Ukuthwala kweZintombi*." This cultural practise forces girls into marriage with older men. Political leaders mentioned "other" challenges in 17% of all speeches and lack of implementation of the National Action Plan to end GBV, lack of resources and inefficient public health system in three percent of speeches.

Case Study: GBV Discourse by Minister of Women, Children and People living with Disability
By Ticha Tsedu

The fight against gender-based violence (GBV) is one requiring concerted efforts from communities, the private sector, civil society, as well as government. Government has a particularly important role to play in this regard given its immense responsibility to provide political and social leadership in the country. To this effect, political discourse analysis serves to measure government's commitment to ending GBV through an analysis of speeches addressed by government officials and political leaders. From a total of 51 speeches addressed between March 2010 and April 2011, GL identified 16 speeches for analysis.

Beginning with aspects of gender-based violence, the minister mentioned sexual offences and rape most frequently, closely followed by child abuse and human trafficking. Less mentioned topics include domestic violence as well as *ukuthwala*. The minister

referred to the broad term GBV and did not address specific forms of gender violence such as economic violence, psychological abuse and abuse against men. In the speeches analysed, the minister did not mention hate crimes against homosexuals and transgendered individuals; a form of victimisation occurring frequently in the country.

Luluama Xingwana is South Africa's current Minister of Women, Children and People with Disabilities. *Photo courtesy of Google Images*

Most of the commitment detailed in the selected speeches referred to numerous laws which have been introduced by government to address violence against women and children. The most frequently discussed of these laws is the Children's Act, followed by the Domestic Violence Act. Also mentioned is the Sexual Offences Act and the Child Justice Act. Although important, legislative measures should not be seen as the most effective way to deal with gender violence and violence against children. Human resources and capacity building remain equally important measures which should be made visible and available through government initiatives in cooperation with civil society and the private sector.

With regard to available support measures, the minister widely discussed Family Violence, Child Protection and Sexual Offences (FCS) units, as well as integrated approaches, namely Thuthuzela Care Centres, as the most discussed support structures. The speeches also mentioned additional human resources (forensic social workers) and the sexual offences court, although limited to one mention each.

Despite these proclamations, the speeches did not mention support such as secondary housing, places of safety, victim empowerment programmes, social and psychological rehabilitation and seeking family support. By not providing this information, those directly and indirectly affected by gender violence have not been sufficiently empowered with knowledge regarding other available support structures. Furthermore, the speeches did not discuss prevention measures such as including GBV in school curriculums and mentioning NGOs that promote gender equality. These critical measures need to be promoted. However the speeches identified the media on two occasions as a crucial means of conveying messaged about ending gender-based violence. The minister identified retributive justice in the form of convictions as a means to deal with perpetrators.

In terms of progress, the speeches frequently mentioned the 16 and 365 Days of No Violence Against Women campaigns. Less frequently mentioned is the Child Protection Week and the United Nations UNiTE to end violence against women campaign. Speeches also made reference to the adoption of an addendum on prevention and eradication of violence against women. Unfortunately, however, the challenges that affect addressing GBV received little coverage. These challenges include unfriendly police, an inefficient criminal justice system and cultural beliefs which justify violence against women and children. Recognition of these shortfalls would be a positive step in effectively addressing gender violence.

There is a major lack of holistic knowledge about GBV in the speeches selected for analysis. Causes do not feature greatly and, without a clear understanding of how the problem arises, it is rather difficult to prevent the problem from occurring in the future. The minister should therefore make more concerted efforts to educate the public about the various origins of gender violence and identify the issues before the situation becomes worse. It is equally important that political leaders address other aspects of GBV in their speeches, including femicide and violence against minorities.

Conclusion

This chapter explored the factors that exacerbate GBV. Among the demographic factors, research found level of education and age as significantly associated with lifetime IPV perpetration. Level of education is also associated with non-partner rape perpetration as men with high school education appear less likely to rape women than men who did not complete high school. This implies that formal education positively influences men's attitudes and behaviour. It is also important to educate men about gender issues to reduce attitudes of male supremacy, which often condone GBV.

The results also show that some attitudes have been changing for the better. This is clear in the finding that shows that men and women agree about the importance of gender equality. However, there is still great need to improve gender attitudes and norms that lead men to feel entitled to use violence against women as an assertion of their power in the domestic domain. Researchers found that attitudes about gender relations seem to overlook the use of violence to maintain male dominance and control women. The study found that community perceptions remain more conservative than individual perceptions, with both men and women affirming that men have the final say in a home and women should obey their husbands. It can be assumed that perpetrators of violence may be taking their cue from the broader community's acceptance of men's dominance over women.

Researchers also identified alcohol and drug use as key drivers of IPV. There is need for further research in this area in order to enable comprehensive interventions to curb IPV perpetration. There is also a need to set up interventions that help regulate and discourage excess alcohol consumption in the country. These may include enforcing and increasing an alcohol tax, regulation of drinking points and amount of consumption per person.

Consistent with findings in other literature, child abuse is a risk factor of IPV and non-partner rape (Abrahams 2006; Anderson 2007; Jewkes 2006). This study found that a greater proportion of men who experienced child abuse reported IPV perpetration and non-partner rape than men who had not been abused in childhood. It is critical to prevent various forms of child abuse. Interventions need to be implemented to teach parenting skills and highlight the issue of child abuse. In addition, it's important to ensure psychological support systems for children who have been abused. Men need to be provided with alternative means of handling aggression and conflict (Abrahams 2005).

The political speeches analysed in this study indicate that government is a long way from sufficiently understanding and addressing GBV. However, government remains an important institution for the promotion of healthy livelihoods for all South Africans. Additional financial and human resources must be made available to address the epidemic of gender-based violence. Without a sufficient financial and moral support from South Africa's leaders, the violence will continue.

CHAPTER 5
EFFECTS OF GBV

Women in South Africa prepare to take back the night during the 16 Days of Activism. *Photo by Gender Links*

Key facts

- More than a quarter (26%) of women who had been physically abused suffered injuries.
- Only 21 (17%) women went to a health facility after sustaining injuries.
- Sixteen (13%) of these women had serious injuries that left them bedridden as a result of assault.
- Seven (6%) of the women took days off work because of the injuries sustained.
- A significantly higher proportion of women who experienced physical IPV in lifetime had been 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 had been diagnosed with STI compared to those who had never been raped.
- More than a third (35%) of IPV survivors and 34% of rape survivors reported an HIV positive status.
- The most common mental health problem among women who had experienced intimate partner violence is depression.
- Almost all (99.9%) survivors of rape, compared to just half (52%) of non survivors, told researchers they felt depressed.
- Twenty-five percent of survivors had suicidal thoughts.
- More than half of men (56%) interviewed believe rape survivors may have been promiscuous.

My name is (Karabo). "My mother was sick, so I was sent to stay with my paternal aunt. My father was sick at that time and he passed away. my father's burial my relatives chased me away. I had nowhere to go. I decided to come to Pietermaritzburg. I then met my boyfriend, Spinach, who fathered my child. I decided to stay with him.

At first we were fine because we drank beer together. We started having problems when he forced me to have sex with him every day even if I didn't want to. He would force me to sleep with him. I fell pregnant and when I told him he still continued to force me to sleep with him. One time we were sleeping and he started touching me, I agreed at first and then I told him that I was tired. When he persisted, I tried to run away but he caught me and started beating me up. I tried to fight back but he overpowered and raped me.

I did not report it to the police. I also did not go to hospital because I was scared that he would kick me out. I continued staying with him while this abuse was happening. I went to the hospital's antenatal clinic. I also took an HIV test that came back positive. I went to see the social worker at Northdale Hospital. I told the social worker about the abuse I was experiencing at home. At that time I loved him and I did not want him to go to jail or anything, I just left it like that. I started taking ARV treatment.

When I disclosed my status, he started swearing at me and beating me up, asking where I got the disease from. He called me names and told me that I am mad. This continued even after the birth of my child. He was getting worse, to the point that he stabbed me in the back while I was running away from him. I went back to the hospital for my check-ups and reported again to the social workers. He was now selling the home brew beer and dagga and he was also using it. The social worker referred me to the shelter. I have been staying at the shelter for six months now and my child is growing. When I look at myself now my life has completely changed; I am no longer smoking and drinking even though sometimes I think about it and how it used to make me forget all the pain in my life and made things easier for me. Now I think nothing beats being with my child and seeing him grow. I do get stressed that as he grows he will ask me about his father. Even though I still love Spinach, and he has promised to marry me, I am thinking about my child.

I want to reconcile with my family and it seems every time the social worker calls them they are not ready to forgive me. I want to start over again and show them that I have changed; I am no longer the same Karabo that they used to know. I know they are angry with me and that Spinach did not pay for the damages for the child as is required by our culture. I thank The Haven and Gender Links for this opportunity to write a story about my life and to know that someone would read my story and listen to my feelings."

Karabo's story typifies the tragedy that befalls many orphans who find themselves in vulnerable positions after the death of one or both parents. When she decides to settle down she meets an abusive partner who demands sex even if she does not feel like it. She falls pregnant with the man's child and finds out she is HIV positive. This news is not well received by her partner and he becomes even more violent, blaming Karabo for getting the virus. At one point he even stabs her with a knife. Through a reference from a social worker, Karabo manages to leave the abusive relationship and join a shelter with her baby. She is looking forward to a new life.

There is ample empirical evidence that GBV has negative mental, physical, economic and social effects on victims and their families. The effects can be both long and short term. The physical effects include injuries, while mental effects include depression, insomnia, fear, to mention but a few. Social effects mainly comprise to re-victimisation and stigmatisation.[18]

[18] Peltzer, K, Pengpid, S. McFarlane , J. Banyini, M. (2013) Mental Health consequences of IPV in Vhembe District, South Africa. General Hospital Psychiatry.

The association between GBV and HIV and STI infection is well documented, with the former increasing the likelihood of being infected.[19] All these consequently affect the victims' participation and performance in economic activities. As long as victims remain economically dependent on a perpetrator of GBV, they remain at high risk of experiencing recurring acts of violence. Another effect of GBV is that it can be transmitted from generation to generation. Young boys who witness mothers being abused are at an increased risk of becoming perpetrators of domestic violence later in life, while girls who have been exposed to similar abusive patterns are more likely to be vulnerable to later victimisation.[20]

Psychological trauma from gender-based violence often leads to depression.
Photo courtesy of Google Images

This chapter reports on the results from the responses of women participating in this study. Researchers asked women questions about their health on a range of indicators, including on contraceptive use, condom use, HIV testing and results, sexually transmitted infections and aspects of their mental health.

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

Physical trauma

Physical trauma can cause injuries which may lead to death or disability. It may also influence substance abuse which, in turn, is associated with occurrence of non-communicable diseases and consequently 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, to name a few. These may influence substance abuse or non-communicable diseases such as hypertension, which may lead to death. In some cases substance is associated with somatoform like irritable bowel or chronic pain and consequently death or disability. In other instances psychological trauma maybe directly associated with negative perinatal or maternal health outcomes such as low birth weight and miscarriages. These in turn may result in death.

Fear and control

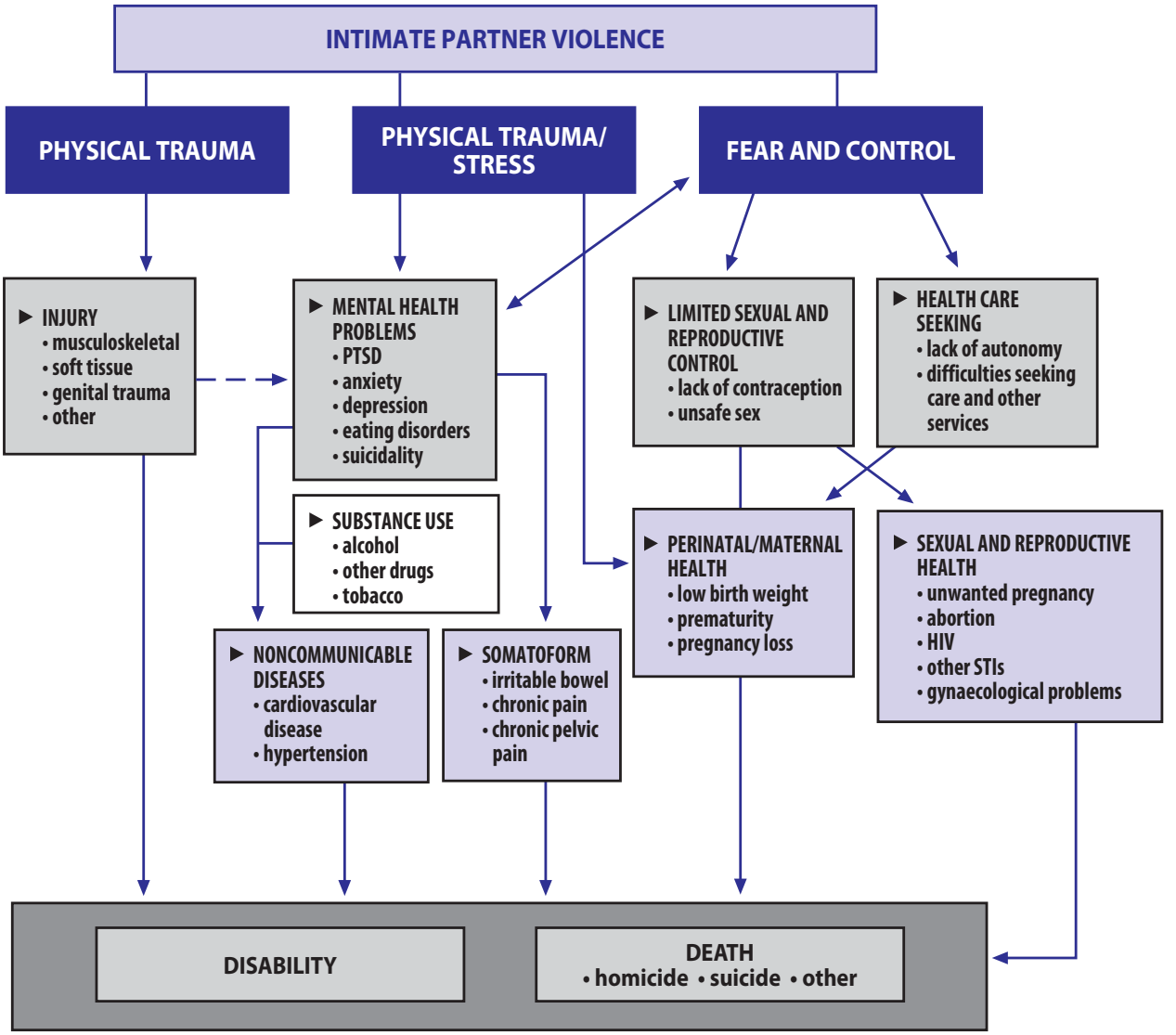
Fear and control may negatively influence health care-seeking behaviour and sexual and reproductive health control as the victims lack autonomy. When a person lacks autonomy it is easy for them to be forced into unsafe sex and difficult for them to seek care and other services. These can have negative effects including unwanted pregnancy, STIs, HIV, miscarriages and low birth weight. Such negative health outcomes may lead to death or disability.

Physical injuries

This study found that GBV experience is often associated with immediate genital and bodily injuries. Researchers asked women who participated in the survey about the injuries they sustained as a result of physical abuse.

[19] Campbell, J,C. & Lewandowski, L. (1997). Mental and physical health effects of IPV on women and children. Psychiatric clinic of North America.
[20] The co-victimisation of the mother and child in relationship to Domestic Violence, RAPCAn, MRC.

Figure 5.1: 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.

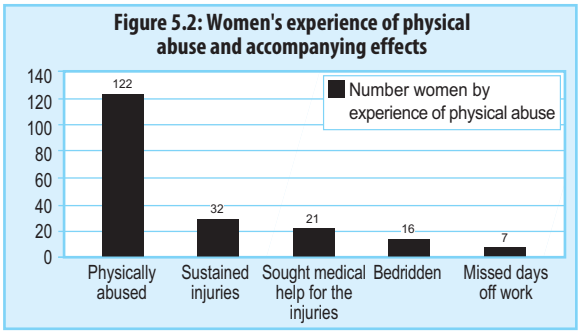


Figure 5.2 illustrates that 32 (26%) women who had been physically abused had sustained an injury. Only 21 (17%) women went to a health facility after sustaining injuries. Sixteen (13%) of these women had serious injuries and became bedridden as a result of assault. Seven (6%) women had to take time off work because of the injuries sustained.

Findings from this study and others (Martin & Jacobs, 2002) show that the health sector often represents the point of first and only contact for abused women; most do not proceed further 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 one of the most effective strategies to prevent further injury and stem the medical and psychological consequences of domestic violence.[21] As such there is need to increase education and training regarding intimate partner violence screening among healthcare providers.[22]

Sexual and reproductive health

For a couple of years KZN has recorded the highest prevalence rates of STI infection in South Africa (Meel, 2005). This is one of the reasons why researchers asked women in this study about their lifetime history of experiences with sexually transmitted infections. Researchers asked women whether they had ever had an ulcer on the vagina, whether they had a discoloured, smelly, itchy or uncomfortable discharge from the vagina and whether they had ever been told by a health worker that they had an STI. The study's findings are shown in subsequent figures.

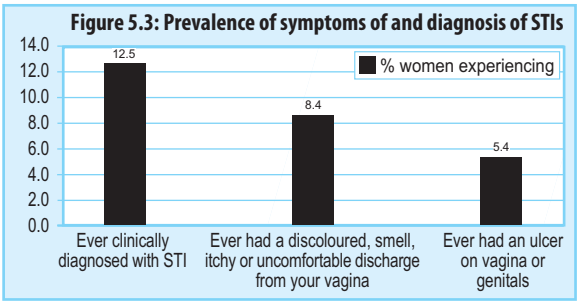


Figure 5.3 shows that 13% of the women interviewed had been diagnosed with an STI at some point in their lifetime. Eight percent of women experienced the symptoms of a discoloured, smelly and itchy vaginal discharge. Five percent had a vaginal ulcer at some point in their lifetime.

The total number of new cases of HIV in KZN in 2010/2011 stood at more than 440,000. In addition, despite a 100% rate of partner notification, only 22% of these had been treated.[23] A study conducted among truck drivers in KZN (Gita et al 2002) found alarming rates of STI: 66% of those interviewed reported having had an STI (STI; discharge or ulcers) in the six months prior to the study. However, 83% had received treatment for these infections. Several factors make KZN a high risk area for STI and HIV infection rates. The province is largely rural and many harmful cultural practices remain common. In addition, the province has a high mobility and migration rate, which is recognised as a risk factor of STI/HIV infection.[24]

[21] Martin, L& Jacobs, T. 2002. Screening for Domestic Violence: A Policy And Management Framework For The Health Sector. Consortium on Violence against Women.
[22] http://www.scielosp.org/pdf/bwho/v86n8/18.pdf
[23] http://www.kznonline.gov.za/hivaids/kzn_psp/KZN%20HIV,%20AIDS,%20STI%20and%20TB%20Provincial%20Strategic%20Plan%202012-2016.pdf
[24] Gita et al, 2002.

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 %	6.4	25.5	7.8	26.0	11.6	19.2	12.0	33.4
P value	0.000		0.000		0.277		0.002	

Table 5.1 shows that a significantly higher proportion of women who experienced physical IPV in their lifetime (26%) had been diagnosed with an STI compared to the proportion of women who had not experienced IPV (6%). Similarly, a higher proportion of women who experienced non-partner rape (33%) had been diagnosed with an STI compared to those who had never been raped (12%). However, researchers found no significant difference in the proportion of women who had been diagnosed with an STI among women who experienced sexual IPV (19%) and those who did not (11%). Sexual violence has always been associated with high risk of contracting STIs (Meel, 2005), thus further research may be needed to explain this anomaly.

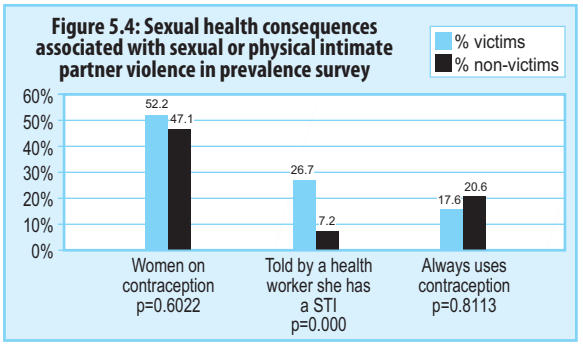


Figure 5.4 shows that a significantly higher proportion of survivors of sexual and physical abuse (27%) had been diagnosed with an STI compared to non-survivors (7%). Researchers found no significant difference in the proportion of victims and non-victims who reported on contraceptive use. The research found 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 its victims, which in turn can act as a barrier to condom or contraception use (WHO, 2013).

HIV/AIDS

This study found men in KwaZulu-Natal are less likely than women to get tested for HIV. *Photo courtesy of Google Images*

South Africa has the world's largest population of people living with HIV and AIDS. As of 2010 it is estimated that 5.7 million people in the country were living with HIV and AIDS, representing nearly a sixth of the global disease burden (UNAIDS, 2010). A 2012 national household survey found that an estimated 6.4 million people live with HIV and AIDS. The estimated prevalence of HIV (the proportion of people living with HIV in the country) increased from 10.6%

[25] 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
[26] Ibid.

in the 2008 HIV Household Survey, to 12.3% in 2012.[25] The study found that KwaZulu-Natal is the province with the highest (27.6%) number of people living with HIV and AIDS.[26]

Previous research in different settings has shown a positive association between GBV and HIV. This study did not test for HIV but researchers asked women if they had been tested for HIV and what result they had obtained.

Table 5.2: HIV testing and results

When did you last have an HIV test	% women	% men
Never tested	37.5	46.2
Last 12 months	36.8	25.0
2-5 years ago	22.7	23.5
More than 5 years ago	3	5.3
HIV Status		
Negative	79.3	91.5
Positive	20.7	8.5

Table 5.2 shows that the majority (62%) of women interviewed had been tested for HIV and the majority of those who had been tested (37%) had done so in the 12 months prior to the survey. It is also noteworthy that more than a third of the women in this study said they have never been tested for HIV. This finding is revealing, especially considering that in 2010 the KZN provincial government rolled out an HIV Counselling and Testing Campaign (HCT) which raised awareness about the need to know one's HIV status.[27] This result is also cause for concern considering that KZN is known for particularly high prevalence and incidence of HIV. Of the women who collected their HIV test results, 21% reported an HIV-positive status. This is evidence for the need to upscale HIV awareness programmes, particularly in remote rural areas.

It appears testing is even less common among men in KZN. Researchers discovered that 54% of men, compared to 62% women, had been tested for HIV. Twenty-five percent of men had been tested for HIV in the last 12 months prior to the study and 23% had been tested between two and five years prior to the study. The proportion of HIV-positive men (9%) is lower than the proportion of women who said they are HIV-positive (21%). Consistent with results from other studies, women remain disproportionately infected with HIV (McPhail 2002). This indicates a need to continue focusing on preventing HIV infection among women of all ages.

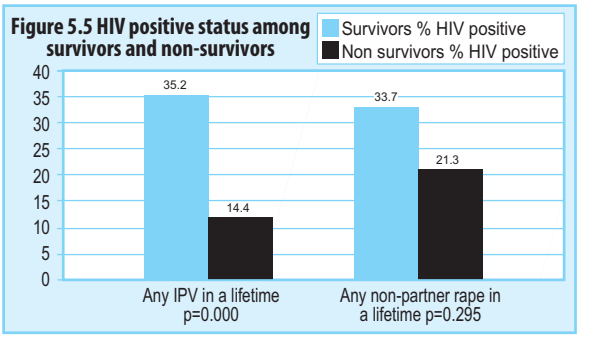


Figure 5.5 shows that a significantly higher proportion (35%) of IPV survivors reported an HIV-positive status compared to non survivors (14%). However, for survivors of non-partner rape there is no statistically significant difference between HIV-positive and HIV-negative women. Various studies in South Africa and worldwide have shown a significant association between rape and HIV infection (Meel, 2005). Rape is often characterised by physical trauma, which increases the risk of HIV transmission.

Consistent with other studies on GBV,[28] researchers found that women who experienced violence are more likely to be HIV-positive or have an STI. This study found low levels of testing for HIV among the participants. The association between experience of IPV and being HIV positive is highly significant, with more than half of IPV survivors compared to just a third of non-survivors reporting an HIV-positive status. It is evident from these findings that GBV is interlinked with HIV and thus concerted efforts must be taken to detect GBV early and try to prevent its progression,

[27] http://www.kznhealth.gov.za/simama/hct.htm
[28] Mary Ellsberg and Myra Betron, Preventing Gender-Based Violence and HIV: Lessons From the Field, Spotlight on Gender (2010)

and consequently HIV infection. This is further evidence of the need for health care professional to test for HIV immediately following a reported assault.

Mental health

Mental health is an important foundation for the attainment of emotional, intellectual, economic, social and educational well-being. Accordingly, mental disorders can be seen as an important contributor to the worldwide burden of disease (WHO, 2001). As highlighted in the conceptual framework, GBV can result in mental health disorders. South Africa put forward the Mental Health Care Act in 2002 (and promulgated it on 15 December 2004). The Act seeks to ensure that the care, treatment and rehabilitation of persons who are mentally ill conform to the Constitution and, in particular, the right to equality and dignity, both founding principles and rights enshrined in the Constitution. Researchers in this study asked women about experience of mental health disorders, including suicidal thoughts and depression.

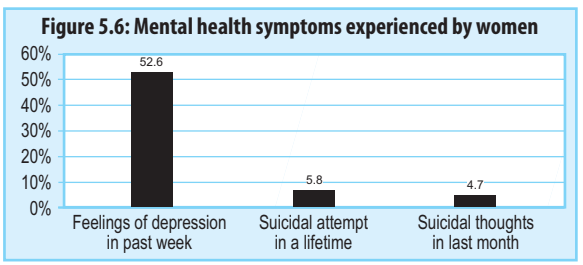


Figure 5.6 shows that more than half (53%) of women reported feeling depressed in the week prior to the survey. Six percent of women had attempted suicide in their lifetime and 5% experienced suicidal thoughts in the month before the survey. These findings demonstrate the scale of mental health issues in KwaZulu-Natal province. This raises a question about whether the health system is adequately prepared to meet these mental health needs. Burns' (2010) analysis on the budget allocations to mental health services in KZN established that there is inequitable funding, inadequate facilities and significant shortages of mental health professionals and psychiatric services in the province.

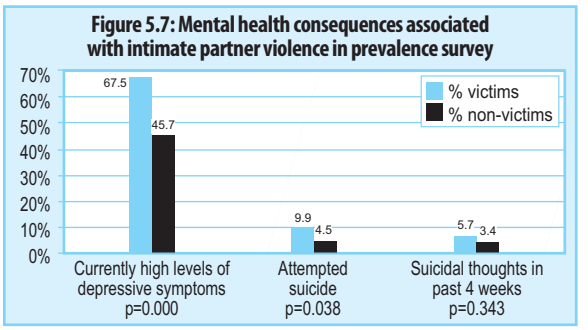


Figure 5.7 shows the proportion of women with current mental health problems among victims and non-victims. The most common mental health problem among women who had experienced intimate partner violence is depression. Sixty-eight percent of survivors compared to 46% of non-survivors expressed high levels of depressive symptoms at the time of interview. About a tenth of women who had been abused disclosed attempting suicide. This proportion is double that found among women who had not experienced physical or sexual IPV. Six percent of survivors compared to 3% of non-survivors experienced suicidal thoughts.

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, 2005). Mental health interferes with women's agency and their ability to engage in economic activities or to leave violent relationships.[29] If left unattended, these effects can contribute to perpetuating occurrences of GBV. This calls for vigorous efforts to provide psychosocial support to victims of violence as well as to empower them to be survivors.

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

Figure 5.8: Mental health consequences associated with rape by non-partner in prevalence survey

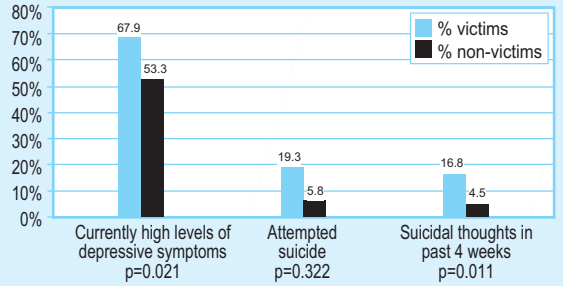


Figure 5.8 shows the prevalence of poor mental health symptoms among rape survivors and non-survivors. A significantly higher proportion of women who had been raped had very high levels of mental ill-health compared to levels among women who had not been raped. More than two thirds of women who had been raped expressed very high levels of depressive symptoms. A higher proportion of women who had been raped by a non-partner attempted suicide. Researchers found these women were more likely to have had suicidal thoughts in the previous week compared to women who had not been raped.

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=0.211	49	67.9
Suicidal attempt in lifetime P=0.007	4.4	16
Suicidal thoughts P=0.138	3.4	8.4
Rape experience		
Feeling depressed P=0.000	51.9	99.9[30]
Suicide attempt in a lifetime P=0.686	5.7	8.9
Suicidal thoughts P=0.039	4.6	25.4

"Two years back, I took an overdose of pills in an attempt to commit suicide. Though I was trying to hide it, my daughter saw and went to tell my husband and he said 'don't worry she will sleep it out and I will be free to do what I want.' The following day he phoned my parents, claiming he didn't know what happened to me. When my parents came my daughter told them the truth. He was forced to take me to the hospital where I was put on life support for four days. When I came out of hospital he said he was upset that I didn't die." Becka

Table 5.3 shows that a significantly higher proportion of physical IPV and rape survivors attempted suicide in their lifetime and experienced recent symptoms of depression or suicidal thoughts ($p<0.05$). More than two thirds (68%) of women who experienced physical IPV in the 12 months before the survey reported feeling depressed compared to 49% of women who did not experience physical IPV in a similar period. Sixteen percent of physical IPV survivors compared to 4% of non-survivors attempted suicide while eight percent of survivors and three percent of non-survivors had suicidal thoughts. Almost all (99.9%) survivors of rape compared to just half (52%) of non-survivors felt depressed. Twenty-five percent of rape survivors and 5% of non-survivors had suicidal thoughts. There is no statically significant difference between survivors and non-survivors of rape in regards to attempting suicide.

Participants from the *"I" Stories* shared their experiences, highlighting similar issues as the women surveyed. The excerpt provided here documents Becka's attempt to commit suicide as a result of IPV.

[30] This figure constitutes nine of the 10 women who reported being raped in the past 12 months before the survey.

The findings from this study are consistent with a study carried out by Pillay and Kriel among women who sought district level clinical psychology services within the Msunduzi municipality in 2004. According to their study, 17% of women reported suicidal behaviour. Both results also tally with international data. If left unattended, depressive symptoms may claim even more lives. According to Schlebusch (2012), deaths by suicide comprise 10% of non-natural deaths in South Africa in young people. This rate can be translated into approximately one to two suicides and 20 or more suicidal attempts per hour (Schlebusch 2012). It is also estimated that by 2020, global suicidal rates will increase to one death by suicide every 20 seconds and one suicidal attempt every two seconds (Bertlote, 2001). Such findings call for urgent attention. There is need to develop appropriate therapeutic interventions as well as upscale mental health services to prevent suicide from occurring in South Africa.

Stigma and secondary victimisation

The social effects of rape on women include being blamed and condemned by their communities. Apart from being blamed there is stigma or labelling associated with having experienced rape. Women and men participating in the survey responded to questions on their personal views, and the views they perceive their community to hold, about rape survivors.

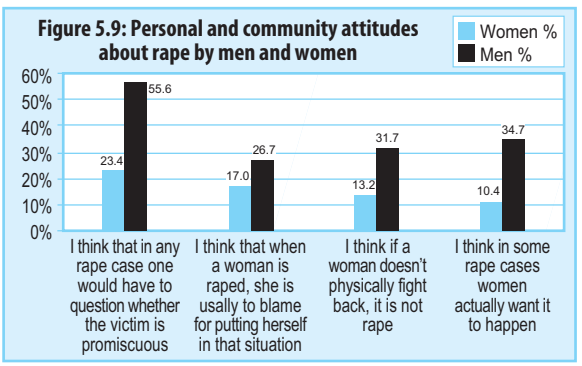


Figure 5.9 shows that a greater proportion of men than women exhibit attitudes that blame and stigmatise rape survivors. More than half the men (56%) surveyed believe that rape survivors may have been promiscuous, 35% said in some cases women wanted it to happen and 32% said if women did not fight back then it is not rape. Meanwhile, 27% said the survivors put themselves into compromising situations. Though in lower proportions, women also affirmed these notions and agreed that women can often be blamed for rape, wanted it to happen or would not be raped if they had fought back. The levels of stigmatisation of rape survivors are considerably high in this study, particularly among men. The pandemic thrives due to these negative attitudes and prejudices. Reducing the level of stigma attached to rape will encourage more women to open up about their experiences. This will enable the survivor and various support systems available to deal with the situation, thereby promoting better mental health. It is important to target the community, especially men, in raising awareness about GBV in order to reduce the level of stigmatisation of rape survivors.

Intergenerational effects

> *"As for my daughter, she lost all faith and doesn't believe in police. She was traumatised. My son told my husband that 'I am going for karate because of you'."* Becka

As much as GBV affect its victims in many different ways, it should be noted that it also has negative effects on any children exposed to it. Exposure to IPV is distressing to children and is associated with a host of mental health symptoms, both in childhood and later in life. Studies have also shown that male children who are exposed to violence have a higher chance of becoming perpetrators of abuse, and girl children have a higher chance of becoming victims, later in life.[31]

One *"I" Story* participant shared how exposure to IPV negatively affected and impacted her children. From her story it can be deduced that unless her daughter receives psycho-social help, she may become a victim of abuse later in life, especially considering she no longer trusts police. Silence perpetuates the occur-

[31] National Survey on Children's exposure to violence (2011); https://www.ncjrs.gov/pdffiles1/ojjdp/232272.pdf

rence of GBV. As for Becka's son, it appears he is harbouring some anger and yearns for revenge. If this family does not take precautionary measures, this boy may turn out to become a violent man. Thus there is a need to engage young girls and boys and teach them about the harmful effects of GBV so they do not become victims or perpetrators later in life. Schools should make screening and counselling services available for children who have been exposed to violence.

Costs to the economy

To encourage action, it is important to provide policymakers with a clear picture of the implications and impacts of the epidemic of GBV in the province. As elaborated above, GBV creates several social, physical and mental health costs. Furthermore, GBV has quantifiable economic costs, although these do not present a true reflection of the extent of the problems since many cases continue to go unreported. Staff members at the DOJ&CD provided the total costs it incurs in response to GBV.

Table 5.4: Current running cost for the average TCC

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
Cellphones	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 coordinator (219 506.88 per annum, victim assistant officer 177 798.6 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 TCC in South Africa. The total cost per month is R113 592, which amounts to more than R1.3 million per year. Given that South Africa currently has 32 fully operational TCCs, this means that R 43.6 million is being used towards the operation of TCCs nationwide per annum. While KZN has six TCCs, only three are fully functional. Considering just these three fully functional TCCs, KZN is spending R4 089 312 towards the operation of TCCs each year.

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 costs incurred for hiring specialist personnel who respond to gender-based violence. This amounts to a cost of more than R72 million in annual salaries, the majority of which go to intermediaries. The figures presented are high and this underscores the need to shift focus on responsive mechanisms to more preventive measures.

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 16 010 318**

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

Table 5.6 illustrates the costs of the required infrastructure to support victims of sexual offences, amounting to a total of more than R16 million.

Thus, the estimated total amount spent on running TCCs, salaries for specialist staff and money spent on infrastructural services is R132 035 469 (USD$13 164 715). Calculating this number against South Africa's 2012 Gross Domestic Product (GDP) - USD$384.31 billion - means the value of responding to GBV amounts to 0.03% of the country's annual GDP. However, it is important to note that these are costs incurred by one department only - the DOJ&CD. All costs incurred by other departments, such as the DSD, Department of Health and SAPS, have not been established in this study. Equally worth noting 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.

Conclusion

This chapter highlighted the effects of GBV including physical injuries, poor mental health and increased risk of HIV and STIs. The health sector must play a greater role in responding to intimate partner violence and sexual violence against women. The World Health Organisation's new clinical and policy guidelines on the health-sector response to violence against women emphasise the need for GBV to be integrated into clinical training. Screening should be performed on injured persons to facilitate appropriate referrals for victims. The findings presented in this chapter suggest an urgent need for mental health services in South Africa and KwaZulu-Natal.

Psychiatric and mental health services in KZN do not get sufficient funding, nor is there proper infrastructure, development and staffing (Burns, 2010). The mental health effects of GBV are much more far-reaching compared to the physical effects.

To address re-victimisation there is a need to engage more with communities, particularly men. Women also need to be assisted to become survivors. Tackling the economic effects of GBV is equally important. Though it focused on only one department, the financial figures presented in this chapter illustrate there is a need to further document the costs incurred by different stakeholders in responding to, as well as preventing, GBV.

Overall, this chapter shows that GBV is a global public health challenge of epidemic proportions that requires urgent action to avoid preventable deaths and disabilities.

CHAPTER 6
RESPONSE

Policewomen attend a Take Back the Night march during the 16 Days of Activism campaign. *Photo by Colleen Lowe Morna*

Key facts

- More than a third (40%) of all reported sexual offences involved children and nearly half (48.5%) involved adult women as victims.
- Rape accounted for almost three-quarters of all reported sexual offences (73%) recorded nationally.
- Sexual offences comprise the most common crime against children, with 26 955 reported cases in 2011/2012.
- Rape is the most common type of sexual offence reported in KwaZulu-Natal, with a 5% increase from the year 2010/2011.
- Overall, KZN experienced a 5% incidence decrease in total sexual offences in that same period.
- The number of registered names of sex offenders on the NRSO increased from 978 in 2011 to 2 340 in 2012.
- The average conviction rate of sexual offences prosecuted at sites linked to TCCs dropped from 63% to 60.7%.

"In 2011, I (Nothando) was staying with my aunt in a place she was renting. I used to get home from school before her. She knocked off from work at 16:30. One hot afternoon day I got home and I decided to take a bath. As I was bathing another tenant came in the bathroom. He just walked in because the door did not have a lock. He came in and he raped me. While he was raping me one of the other tenants walked in and saw what he was doing. The man who was raping me threatened to harm her and she ran away. The tenant who witnessed me being raped phoned the police and my aunt. My aunt arrived before the police. The police only arrived when we were at the hospital. After the incident I was so scared of going to school.

Days later, I was on my way to the hospital when I saw the man who raped me at the filling station. I immediately phoned the investigating officer and he told me that I should go to Edendale Hospital, which was nearby.

The police officer arrived and together we went to meet the man. The officer asked the man if he knew me. The man said he knew me and confirmed to the officer that we were co-tenants. The investigating officer asked him if he knew there was a rape case against him. The man said he was unaware of this and asked the officer if it were possible for someone to rape a girlfriend? He was not arrested on that day. The police officer told me to go to the hospital and he said I should bring the tests to the police station the following day.

The following day when I got to the police station with the results, I found the man with his family already there. I gave the results to the investigating police officer who confirmed that I was raped. The man who raped me was immediately taken for finger printing.

Days later the police officer came to our house to inform me the case would be tried in court on 14 December. A few days before the court date, I fell sick and was admitted to the hospital. I couldn't attend the court hearing.

While I was in hospital the man's family came to my family to propose settling the rape case out of court in the form of a compensation fee. My family agreed on my behalf without consulting me first. I was sad and angry when I came out of the hospital and I was told about the agreement. The police officer came to my home with the letter stating that the case had been dropped. I did not get any support from my family."

Nothando was raped by a neighbour. While police made headway in identifying the witness and getting the case to proceed to court, her family stood in the way of justice and agreed to settle the issue out of court, without consulting her. Police withdrew the case and released the perpetrator, increasing the possibility that he might rape again.

This section explores the various legal provisions and response systems that have been implemented to respond to GBV, protect the rights of women and promote gender equality.

Ratification to international and regional instruments

One of the indicators for measuring political commitment to end GBV is the ratification and adoption of legal instruments and the existence of institutional mechanisms which facilitate its elimination. Adherence to international conventions and resolutions on human rights both symbolises and enables government commitment to preventing violence (UN-GA, 2006).

South Africa is signatory to conventions to combat gender-based violence through its membership in, and collaboration with, various bodies opposed to GBV, including the Convention on the Elimination of Discrimination against Women (CEDAW), the Beijing Platform for Action (BPA); the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa and the SADC Protocol on Gender and Development.

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

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

South African Declaration on Gender and Development

The heads of state of the Southern African Development Community (SADC), including South Africa, signed a declaration committing their countries to embedding gender firmly into the agenda of their Programme of Action. This includes repealing and reforming all laws and changing social practices which subject women to discrimination. The declaration further commits to protect and promote the human rights of women and recognise, protect and promote the reproductive and sexual rights of women and the girl child as well as take measures to prevent and deal with the increasing levels of violence against women.

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

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

Legal framework

Apart from the ratification of regional and international frameworks, an effective legal instrument to end violence against women demonstrates a government's commitment to uphold human rights. South Africa has laws in place to address GBV in public and private life.[32]

Informed by the above outlined international and regional conventions the South African government has adapted legislative frameworks accordingly as follows:

- Domestic Violence Act, 1998 (Act No 99 of 1998), implemented on 1 November 1999. A draft bill to propose amendments to the Domestic Violence Act, coordinated by the Dock;
- Criminal Law Amendment (Sexual Offences and Related Matters) Act, 2007 (Act No 32 of 2007), implemented in phases as from December 2007;
- The Protection from Harassment Act, 2011 (Act No 17 of 2011);
- The Children's Act, 2005 (Act No 38 of 2005), implemented on 1 April 2010;
- The Child Justice Act, 2008 (Act No 75 of 2008), implemented on 1 April 2010;
- The Older Persons Act, 2006, implemented on 1 April 2010; and
- The Prevention and Combating of Trafficking in Persons Bill, at present being deliberated upon by the Portfolio Committee on Justice and Constitutional Development.

Domestic Violence Act (DVA)

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

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

[32] National Survey on Children's exposure to violence (2011); https://www.ncjrs.gov/pdffiles1/ojjdp/232272.pdf

Sexual Offences Act (SOA)

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

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

Public awareness of national legislation

Researchers asked participants in the prevalence and attitudes survey whether they knew about the DVA and SOA.

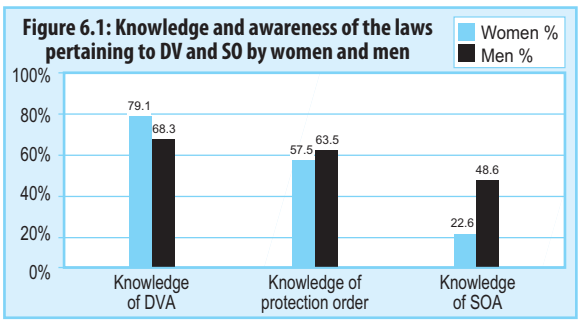


Figure 6.1 illustrates men's and women's responses regarding their awareness of South Africa's existing laws that address domestic violence and sexual offences. It is evident and ironic that generally men have a better knowledge about the laws that protect women against violence. The study found that more women (79%) than men (68%) know about the DVA. More men (64%) expressed knowledge about protection orders compared to women (58%). Meanwhile, only 23% of women knew about the sexual offences act, while almost half (49%) of the men reported awareness on it. It is evident that there is a need to continue to raise awareness about these laws, especially among women.

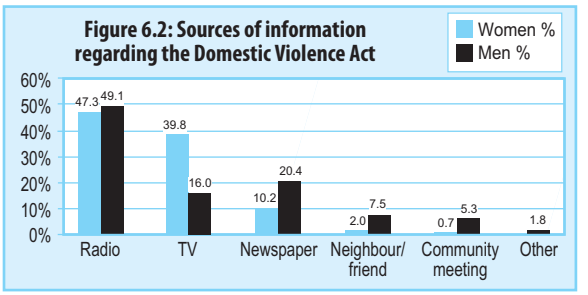


Figure 6.2 illustrates that the radio is the number one way men and women access information about the DVA. Forty-seven percent of women and 49% of men heard about the DVA through on the radio. TV seemed to be more popular among women (40%) than men (16%). But more men (20%) than women (10%) learned about the DVA in a newspaper. A greater proportion of men (13%) heard about the DVA from neighbours or at community meetings, while only 3% of women accessed information in this way. These findings provide evidence of the need for greater outreach efforts in order to educate South Africans about the country's GBV legislation.

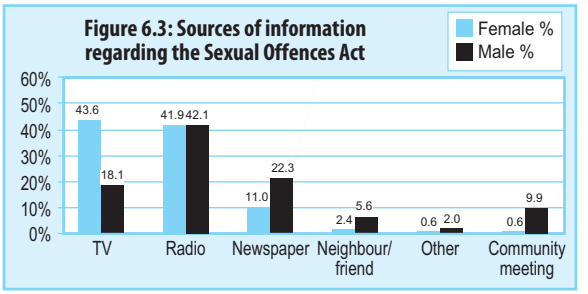


Figure 6.3 shows that the majority of women (44%), compared to only 18% of men, heard about the SOA on a television programme. Forty-two percent of

women and men heard of the SOA on the radio. Meanwhile, 20% percent of men and 11% of women learned about the SOA in a newspaper. Eight percent of men compared to 3% of women heard about the SOA through a friend or neighbour and 10% of men and just 1% of women heard about the legislation at a community meeting.

These findings show that the women mostly access information at home, on either the television or radio while men are more likely to get information about legislation from friends or neighbours, or at community meetings.

These findings reveal the different ways men and women access information on laws. These finding underscore the need to publicise information on television and radio in order to have the maximum outreach. However, there is also a need to accelerate dissemination efforts through other modes, for example through community mobilisation and the print media.

Evaluation of the DVA and SOA implementation

The SAPS and the DOJ&CD act as the chief custodians of both the DVA and SOA. However, research has identified gaps in the implementation of these acts. One of the main problems involves inadequate resourcing allocated for the implementation of these important pieces of legislation.

According to research undertaken by Tshwaranang Legal Advocacy Centre (TLAC), several police stations do not have the required resources to carry out the procedures stipulated by the acts. Also evident is that key stakeholders, including police, remain ignorant about the fundamental issues pertaining to these acts. There is ambiguity in the DVA on the issue of delegation of responsibilities: while the DVA places responsibilities on only one department, the SAPS place no corresponding legal obligation on other relevant stakeholders, such as the DSD and the Department of Health.

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

In accordance with the international trend pertaining to responding to victims of domestic violence, South Africa implemented significant victim-centred policies. This approach seeks to bring different disciplines together including the police, medical officers, social services and criminal justice. As such the respective sectors have also created their own departmental policies that speak to providing 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, the cabinet approved a Service Charter for Victims of Crime in South Africa as well as Minimum Standards on Services for Victims of Crime. It is intended to assist in the implementation of the Victims' Charter. The Victims' Charter and Minimum Standards provide an important framework for the consolidation of all laws and policies in relation to the rights of and services provided to victims of crime and violence. It is intended that they promote excellence in service delivery thus promoting client satisfaction with the services delivered.[33]

National Policy Guidelines for Victim Empowerment

These National Policy Guidelines provide the regulatory framework for promoting and upholding the rights of the victims of crime and violence in order to prevent re-victimisation within the criminal justice and associated systems. In addition, it provides a framework to guide and inform the provision of integrated and multi-disciplinary services aimed at addressing the diverse needs of victims of crime and violence effectively and efficiently.[34]

[33] Source: http://www.npa.gov.za/files/Victims%20charter.pdf
[34] Source: http://www.npa.gov.za/files/Victims%20charter.pdf

The Integrated Strategic Framework for the Prevention of Injury and Violence (i.e. interpersonal violence)

Lawmakers developed the Integrated Strategic Framework for the Prevention of Injury and Violence (i.e. interpersonal violence) in November 2011. It incorporates a plan for response to violence. The framework development included a multisectoral approach with other national departments, provincial departments of health, civil society organisations and academic and research institutions, including the Medical Research Council. This strategy enhances the capacity to reduce the high burden of injury and trauma, especially from road accidents, interpersonal violence and violence against women and children. The technological and professional staff capacity of the forensic laboratories has been increased to support the justice system.[35]

Health sector

Public health approaches have been shown to be critical in responding to GBV. In line with this, the National Department of Health (NDOH) has implemented a policy to guide treatment and care of victims of sexual assault and domestic violence. The main health policy related documents include 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, service to victims of abuse requires cooperation between the health sector, the police and the Department of Justice. It stipulates provision of counselling and referral of victims, STD prophylaxis and HIV testing, emergency contraception, care of injuries, medico-legal advice and documentation of evidence. The norms and standards for service include that:

- Every clinic should establish working relationships with the nearest police officer and social welfare officer by having 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 NGOs or other organisations (e.g. CBO) which undertake appropriate counselling (e.g. FAMSA, 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.
- Clinic staff should fast track in a confidential manner any rape victim to a private room for appropriate counselling and examination.
- Clinic 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.
- Clinic 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 allegation should be assumed to be true and the victim should be made to feel confident they are believed and are 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 is taken and noted - with an indication that these are not a full account. These notes are kept for three years.
- Clinic staff should explain that referral is necessary to an accredited health practitioner and arrange-

[35] (Department of health report 2011-2012) http://www.doh.gov.za/docs/reports/annual/2012/Health_Annual_Report_2011-12.pdf

ments are made expeditiously and while awaiting referral emergency medical treatment is 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 and 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 comes to the clinic) then another woman is 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)

National Management Guidelines for Sexual Assault Care

Women who have been raped have particular health needs which include supporting their mental health, preventing pregnancy, HIV and other sexually transmitted infections, and the management and documentation of injuries.[36] The National Management Guidelines for Sexual Assault Care or "National Guidelines," developed by the South African National Department of Health (DOH) in 2004 provide an example of a notable achievement of 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 including emergency contraception and referral of HIV-positive patients for further HIV management.[37]

These guidelines 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

Individual responses of police or health personnel can exacerbate or ameliorate the negative impact of GBV. South Africa has seen some progress at departmental level and among Civil Society Organisations (CSOs) in providing services to survivors of GBV. Most government departments have been oriented towards response and support while CSOs have focused on support and prevention campaigns. Client data is collected as a routine exercise whenever survivors access these services. For this chapter, researchers obtained data on access to services by liaising with respective departments and organisations. In instances where service providers did not make information readily available, the research made use of past annual reports and information from organisational websites.

South African Police Services (SAPS)

According to the Domestic Violence Act (DVA) it is the responsibility of every member of the SAPS to avail him or herself at the scene of an incident of domestic violence in as little time as reasonably possible or when the incident of domestic violence is reported. They should then render such assistance to the complainant as may be required in the circumstances. This includes assisting or making arrangements for the complainant to find a suitable shelter and obtain medical treatment if necessary.

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

[36] 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.
[37] Republic of South Africa National Sexual Offences Act.

Some of the failures may include failure to:

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

Specialised units within SAPS

In order to better respond to VAW, SAPS has created specialised units whose sole responsibility is to address issues of domestic violence at police station level. To ensure that police take statements regarding GBV behind closed doors and in privacy, SAPS created 900 victim-friendly rooms. Currently 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.[38]

The Child Protection Unit

Police established this unit to prevent and combat crimes against children. It deals with cases of rape, incest and sexual exploitation among many others. Government has demonstrated leadership in ensuring that the constitution, legislation, policies and international instruments provide statutory protection towards ensuring a better life for children. The Children's Act of 2005 sets out the principles relating to the care and protection of children and defines related parental responsibilities and rights. It is important that children know and understand their rights. The act sets out general principles and promotes the best interests of the child.[39]

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

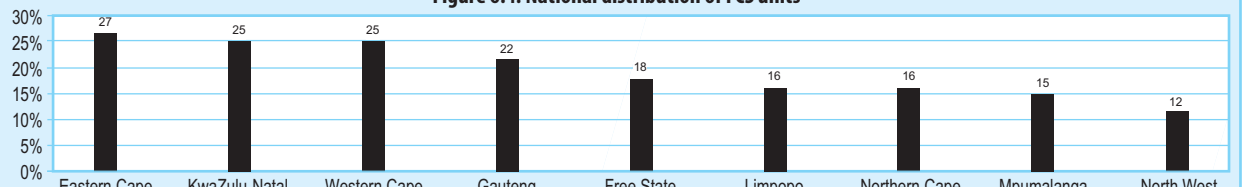
Family violence, child protection and sexual offences (FCS)

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

FCS units have been reintroduced in all 176 SAPS clusters across the nine provinces. The SAPS has currently placed 2155 detectives placed at these units, issued with 1276 vehicles. Previously, the FCS units consisted of only 1 864 detectives.[40]

Figure 6.4 shows the distribution of the 176 units across the nine province of South Africa.

Figure 6.4: National distribution of FCS units



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

Figure 6.4 illustrates that Eastern Cape has the highest number of FCS units in the country and North West province has the least. The SAPS has 27 units in Eastern Cape. KwaZulu-Natal and the Western Cape each have 25 units. Gauteng province has 22 units and Free State has 18. The number of FCS units in KwaZulu-Natal account for 14% of all units in the country. The 25 units serve 184 stations in KwaZulu-Natal. Taking into consideration this study's finding of high prevalence of GBV in the province, there is a need for continual training of specialists to ensure an adequate labour force to deal with GBV issues.

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 not done much to improve services to the victims of violence. Rather, they found the structure after the process unable to offer continued specialisation of officers nationally, dedicated resourcing and specialised management and oversight of FCS cases.

The research identified many gaps, including that the restructuring resulted in the placement of FCS staff in service-delivery positions where they had not been: (1) suitably trained, (2) did not have suitable experience, (3) did not undergo special screening or selection, (4) had not specifically elected to work on FCS cases, (5) and did not have some of the basic requirements to undertake the job, e.g. driver's licenses.[41]

Victim Friendly Rooms

The SAPS has installed Victim Friendly Rooms (VFRs) at various locations to which survivors of GBV can be referred. These rooms aim to provide a private and comfortable environment where survivors can be informed about their rights and the available options relating to their situation[42]. The atmosphere of confidentiality and privacy in the rooms is meant to enable survivors to give statements with ease. The police officers found at VFRs should be especially trained to carry out their investigations and their provision of specialised services to survivors with sensitivity.[43]

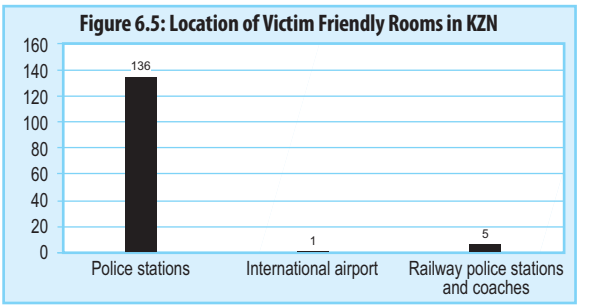


Figure 6.5 illustrates that KwaZulu-Natal has a total of 142 Victim Friendly Rooms. The majority of these (136) can be found at police stations. Five VFRs have been located at railway police stations and coaches and the international airport has one VFR. The KwaZulu-Natal province does not have VFRs at satellite police stations and FCS Units. This shortfall needs to be addressed and VFRs must be created at satellite police stations and FCS Units. It is also important that, if necessary, the VFRs have access to the services of a trauma centre at which the physiological needs of the survivors can be adequately addressed while police take statements. Some survivors have been known to withdraw cases against perpetrators, especially when a case involves intimate partner violence. Since it is the role of VFRs to provide the survivor with information on their options, VFRs should adequately empower, and offer support to, survivors so as to minimise situations in which survivors drop charges.

Forensics unit

Specialist services providers such as forensic social workers offer specialised technical analysis and support to investigators regarding evidence on gender-based violence related cases. According to Deputy Minister of Police Maggie Sotyu, police granted 36 225 years imprisonments and 695 life

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

imprisonments to perpetrators of GBV during the 2011/2012 period through the evidence provided by the Forensic Science Laboratory.[44]

The role of the ICD in the implementation of the DVA by SAPS

Since its inception the Independent Complaints Directorate (ICD) has been responsible for monitoring the SAPS in its implementation of the DVA. Any interested persons, victims of domestic violence and staff at non-governmental organisations can lodge a complaint with the Independent Police Investigative Directorate (IPID) if they feel that any member(s) of the SAPS failed to comply with the provisions of DVA.

Various types of non-compliance cases included: failure to arrest the alleged transgressor; failure to open a docket and refer the matter to the prosecution; failure to advise complainants of options (e.g. to lay a criminal charge or apply for a Protection Order or both); and failure to keep a copy of the Protection Order after it had been obtained from court. However, since the 2011 IPID Act, Act 1, came into effect on 1 April 2012 the IPID no longer has a mandate to deal with any domestic violence related non-compliance matters. The act instead conferred the duty on the Secretariat for Police.[45]

Over the years, the ICD has continuously experienced challenges in implementing the DVA. According to its last report to the parliament, the SAPS's major challenge is maintaining an acceptable level of regulatory compliance in terms of administrative abilities and record keeping in line with the DVA and National Instructions.

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

Police audits

According to the Compliance with National Instructions 3/2008, a police station is supposed to have a set of nine documents that provide guidelines for service provision to ensure that police offer comprehensive services.[46] The nine documents are as follows:

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

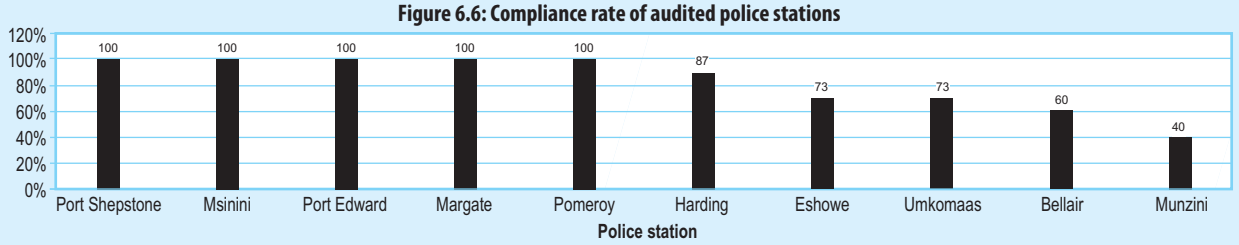
The KZN ICD provincial office conducted audits at 10 police stations to determine the level of compliance with the DVA and the National Instruction. Part of the audit included:

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

Figure 6.6 outlines the compliance rates found in the audited police stations in the period of 1 July to 31 December 2011.

[44] http://www.info.gov.za/speech/DynamicAction?pageid=461&tid=99977
[45] http://www.ipid.gov.za/documents/report_released/dva_reports/2010-2011/ICD%20-%20DVA%20%20July%202011%20-%20March%202012.pdf
[46] ibid.

Figure 6.6: Compliance rate of audited police stations



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

The auditors found full compliance at five of the 10 stations audited, namely Port Shepstone, Msinini, Port Edward, Margate and Pomeroy. The audit found Harding police station 87% compliant, followed by Eshowe and Umkomaas police stations at a 73% compliance rate. Bellair and Mtunzini recorded the lowest compliance rates of 60% and 40% respectively. Some of the non-compliance findings included;

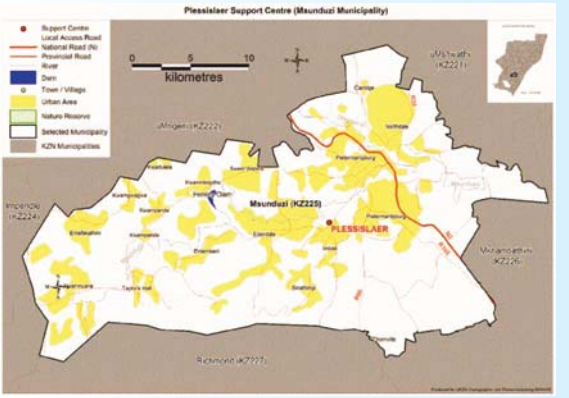
- No Domestic Violence Register, SAPS 508(b) in Client Service Centre (CSC);
- No SAPS forms 508(a) available in CSC;
- Responses to domestic violence incidents not recorded on SAPS forms 508(a);
- The SAPS 206 of members not maintained;
- Monthly procedures of File 39/4/2/3 on DVA incidents not maintained;
- Procedures of SAPS 10 on DVA not thoroughly maintained;
- Protection orders not served;
- Copies of protection orders received not filed; and
- Copies of warrants of arrest received not filed.[47]

A case study of Plessislaer police station in KwaZulu-Natal

Case studies on the SAPS response strategies to violence against women can be derived from the Shukumisa Report 2011/2012. It assessed police stations on the following indicators, which can be used to measure the ability of the SAPS to respond promptly and effectively to the challenge of violence against women in the community:[48]

- Accessibility to the public - the inaccessibility of police stations serves as a hindrance to women who might need help. It is important that police stations be easily accessible to the public to enable timely reporting of offences. The "public" is all individuals in a community, including people living with disabilities. The report considers police stations accessible if they fall within a 1km radius from some form of public transport;
- The Client Service Centre - including availability of educational pamphlets and posters on GBV;
- Availability of documentation associated with the SOA; and
- Specialised station-level services.

Accessibility



[47] http://www.ipid.gov.za/documents/report_released/dva_reports/2010-2011/ICD%20-%20DVA%20%20July%202011%20-%20March%202012.pdf
[48] Shukumisa Report 2011/2012.

Plessislaer police station in KwaZulu-Natal is an example of a police station that is not within a 1km radius from public transport. Additionally, the police station is not easily accessible to people living with disabilities - including those who use wheelchairs because it does not have a ramp. However, the police station has the capacity to deal with sexual offences perpetrated against people living with mental disabilities and the deaf.

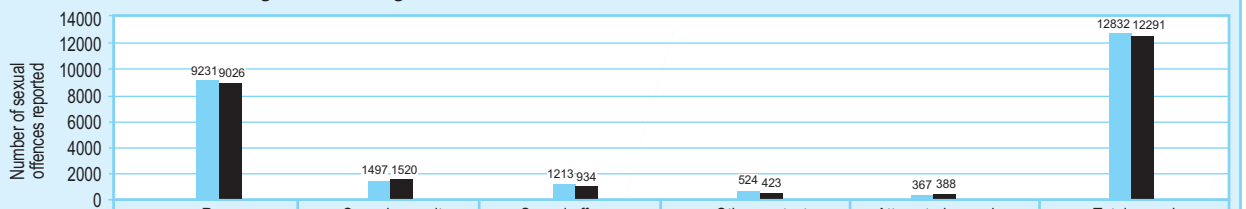
Availability of documentation
Plessislaer station had all the nine documents. These documents inform the police on a variety of issues. For example, this includes the notice containing information on confidentiality of, and how to deal with, the results of HIV tests. In addition, the document informs officers how to protect the privacy of the survivor and includes a list of organisations providing services to rape survivors and hospitals providing PEP. Such documents empower the survivors by providing necessary information about where they can get comprehensive psychological and medical care. It is commendable that Plessislaer station had these nine documents. However, station management must ensure that police officers know how to implement the contents of the documents. Police officers need to be continually trained on executing the recommendations in the nine documents.

This case study of Plessislaer shows that while efforts have been made to offer adequate services to survivors of GBV, the SAPS still need to strengthen response mechanisms, including accessibility of police services to the public.

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

The overall national sexual offence rates show a decrease of 3.7% from 2011 to 2012. Rape, according to the new, more inclusive definition that covers vaginal, oral and anal penetration, accounted for three quarters of all sexual offences (74.5%) recorded nationally. This crime decreased by 2.5% from the previous year (SAPS National Crime Statistics Annual Report 2011/2012).

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



	Rape	Sexual assault	Sexual offences detected by police	Other contact sexual crimes	Attempted sexual offences	Total sexual offences
2010/2011	9231	1497	1213	524	367	12832
2011/2012	9026	1520	934	423	388	12291

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

Figure 6.7 shows the different forms of sexual offences reported in the year 2011/2012 in KZN. The number of cases reported varied among the different forms of sexual offences. SAPS found rape to be the most dominant type of sexual offence, with 9026 cases. Sexual assault constituted 12% of sexual offences, while sexual offences detected by police constituted 8% of all the sexual offences. Other contact sexual

offences and attempted sexual offences constituted 3% of the total sexual offences committed in KZN province in the year under review (SAPS National Crime Statistics Annual Report 2011/2012).

Figure 6.7 also shows a decrease in the total sexual offences between 2010/2011 and 2011/2012. Overall, KZN experienced a 4% decrease in total sexual offences reported. It is also evident that there is not much difference in all the sexual offences reported between the years 2011 and 2012. (SAPS National Crime Statistics Annual Report 2011/2012).

Table 6.1: KZN Sexual offences incidence rates for women, 2012

Type of sexual offence	Number of cases 2011/2012	Midyear population (females) 2011	Incidence rate females
Rape	9026	3 838 320	2.4
Sexual assault	1520	3 838 320	0.4
Sexual offences detected by police	934	3 838 320	0.2
other contact sexual crimes	423	3 838 320	0.1
Attempted sexual offences	388	3 838 320	0.1
Total sexual offences	**12 291**	3 838 320	3.2

Table 6.7 illustrates that the incidence rate for the adult female population is 3.2, which means that three in every 1000 females experienced some form of sexual offence in 2012. These statistics prove relatively low compared to figures obtained from this study.

Department of Justice and 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 Domestic Violence Act (DVA) and the criminal law (sexual offences and related matters) Amendment Act 32 of 2007(SOA). Domestic violence divisions that provide exclusive services for victims of DV can be found in all 476 magistrate's courts that deal with domestic violence matters. Six of these courts provide dedicated domestic violence services.

Similarly, 298 regional courts have been dedicated as sexual offences courts (SOCs) that offer special services to victims of sexual violence. There are also 15 SOCs and six family courts that offer exclusive specialised services.[49] The DOJ&CD has agreed to the Ministerial Advisory Task Team's recommendation on the Adjudication of Sexual Offences Matters (MATTSO) to re-establish the SOCs in South Africa. It is anticipated that the project will stretch over three years and that 57 regional courts will be upgraded to meet the requirements of the new developed SOC model.[50]

The Role of the Criminal Justice system

The court-based support services to victims of domestic violence and sexual offences include:

Intermediary services

The intermediary provides specialised support to the witness by sensitively and cohesively conveying to him/her questions coming from the court.

In-camera court support services

In compliance with the law, the department offers in camera proceedings to ensure that the victim testifies

[49] DOJ&CD: Project on investigating expenditure relating to GBV: Questions.
[50] ibid.

in a separate room from the courtroom and away from the physical presence of the accused. The main reason is to prevent secondary trauma. The DOJ has committed to creating specialised services in sexual offences and child-friendly courts. It has committed funds to the progressive procurement of audio-visual court equipment and the creation of witness testifying rooms. 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; and
- 195 anatomically correct dolls.

The DOJ purchased these dolls to assist child witnesses of sexual offences to testify in court with the demonstrative expression of their personal experiences using the dolls (DOJ & CD annual report 2011-2012).

In 2011, the Shukumisa campaign monitored 28 courts in the provinces of Gauteng (five), the Western Cape (four), Limpopo (11), the Eastern Cape (seven) and KwaZulu-Natal (one) to assess the availability of these services. It 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.[51]

Court accompaniment services

The DVA allows victims of domestic to testify with the support of not more than three persons so as 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

The court preparation officers offer these to alert the witness on the court process and also to prepare witnesses for court.[52] The department currently relies on the NPA to provide these services. The aforementioned Shukumisa monitoring found that all 28 courts assessed had not received this service and only 56% of courts had 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 defeating the purpose of having specialisation in sexual offences and child abuse matters.[53]

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 must provide information about the DVA to the complainant. A 2001 GAP and MRC study on the impact of the DVA on women in Western Cape reported that the majority of women described the courts as very busy, with the clerk "not having time to help."

More than a decade later, the TLAC study in Gauteng found that court clerks did not make available the help they've been mandated to provide. Another study established that police have done little to assist victims of violence in order to comply with the requirements of the DVA (Lopes et al, 2013). Watson (2012) shared the responses of women at public hearings who said that information had not been made available to them. The study also found that there had been no proper monitoring and evaluation to monitor implementation of the DVA.

Other studies reported that victims have been unable to access information on applications for a protection order or recover their personal belongings from home. They have also struggled to get assistance with obtaining basic medical treatment. The Justice, Crime Prevention and Security Cluster (JCPS) is pursuing plans to address these issues with other partners as it finalises a joint JCPS Domestic Violence Strategy.

Record keeping

The clerk of court receives applications and affidavits for protection orders and then submits these to the court. When a court grants protection orders, it must authorise warrants of arrest and make available a

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

replacement of the warrant at the complainant's request if it is expired or lost. 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 may be used for prosecution, appeals and in other court proceedings such as divorce and custody matters. The TLAC study in Johannesburg, Mpumalanga and Western Cape established that the clerk's files on domestic violence incidents are often inadequate and incomplete. This impinges on further actions that may be necessary to protect victims.[54]

Issuing of protection orders

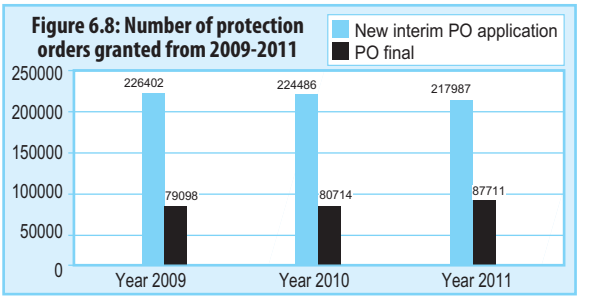
The DVA and the Regulations of the Act set out the duties of the magistrate in domestic violence cases. Broadly, the role of the magistrate in domestic violence cases is to:

- 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.

- 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 provided to the respondent and that the application contains *prima facie* evidence that the respondent has committed or is committing an act of domestic violence.[55, 56]

After the public hearings held by the Portfolio and Select Committees on Women, Children and Persons with Disabilities, the members requested that the DOJ&CD provide information on how many interim protection orders had been issued in the period 2010/2011, as well as the number of final protection orders issued the same period. The results can be seen in Figure 6.8.

Figure 6.8: Number of protection orders granted from 2009-2011



Source: Shukumisa Report, 2013.

Figure 6.8 shows that there is a huge gap between the number of interim orders granted and the final number granted. It can also be noted that from 2009 to 2011, the number of interim orders granted decreased, while the number of protection orders made final slightly increased. The DOJ&CD provided potential reasons for this difference in the number of interim protection orders applied for, and the final orders granted, as follows:

- The loss of interest of the complainant, which is often due to reconciliation with the respondent;
- Sudden lack of cooperation by the complainant or witness, including refusal to testify;
- Respondent or complainant being untraceable; and
- 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.

While the DOJ&CD cited reconciliation with respondent as the reason for loss of interest, it overlooked the fact that many victims lose interest because justice staff treat them with scorn or suspicion.[57] According to Watson (2012) the criminal justice system triggers a form of secondary victimisation which deters victims from taking out an application for a final protection order. This is stated as a critical reason for high attrition levels in the submissions made to Parliament.[58] A TLAC study found that institutional barriers play a role in preventing many women from obtaining due protection from the law. It noted some courts remain

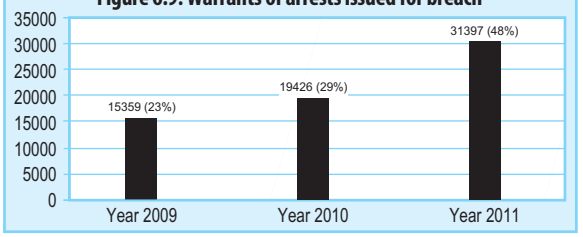
[54] http://www.tlac.org.za/wp-content/uploads/2012/01/Implementation-of-the-Domestic-Violence-Act.pdf
[55] Section 5(2) of the Domestic Violence Act (116 of 1998).
[56] http://www.ghjru.uct.ac.za/osf-reports/magistrates-report.pdf
[57] http://www.mrc.ac.za/gender/domesticviolence.pdf
[58] http://www.shukumisa.org.za/wp-content/uploads/2013/05/Justice-and-DVA.pd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

less likely to finalise protection orders, which could indicate prejudice on the part of some magistrates towards applicants.[59] The department needs to revisit the reasons for high attrition and devise ways to address this problem, including providing better training for its personnel.

Authorisation of warrant for arrest

Whenever the court issues a protection order, it must make another order authorising the police to the arrest the perpetrator if he fails to honour the protection order. Figure 6.9 shows the number of warrant arrests issued from the year 2009 to 2011.

Figure 6.9: Warrants of arrests issued for breach



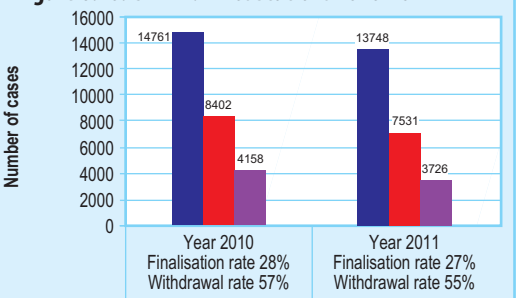
Source: Shukumisa Report, 2013.

This illustrates that arrests have increased, from 23% in 2009 to 29% in 2010 and 48% in 2011. This increase could mean that more perpetrators have been breaching protection orders or it could mean that police have become better at arresting those who breach protection orders. This is an area that requires further study.

Some domestic violence victims choose to pursue a criminal persecution case. Figure 6.10 illustrates the criminal prosecutions of domestic violence in the period 2010 to 2011.

Figure 6.10 shows that the number of new DV criminal prosecutions decreased from 2010 to 2011. The finalisation rates remained low between the two years and the figures show a slight difference in the rates (28% in 2010 and 27% in 2011). Withdrawal rates remained high in the two years, with more than half of the cases withdrawn in both years. While a number of cases did not get withdrawn, a significant number also did not get finalised. The figure shows that victims withdrew 8402 cases in 2010, leaving a remainder of 6359 cases. Of this, courts finalised 3726. In 2011, victims withdrew 7531 cases. Of the remaining 6217 cases, courts finalised 3726, leaving a total of 2491 cases not finalised. It is imperative for the department to report on the reasons why so many cases have not been finalised in order to respond effectively to this huge gap.

Figure 6.10: Criminal Prosecutions 2010-2011



	Year 2010	Year 2011
New matters	14761	13748
Withdrawn matters	8402	7531
Finalised matters	4158	3726

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 department argued that the specification provided by the DVA regarding this issue must not be construed as fully operational 24-hour courts. They further highlighted that this provision has been available in exceptional instances. In such instances, the magistrate courts give the SAPS a roster of officials who can be on call to assist with protection order applications after hours (Watson, 2012).

The following case study outlines the work of the Durban magistrate's court in administering justice related to GBV.

[59] http://www.tlac.org.za/wp-content/uploads/2012/01/Implementation-of-the-Domestic-Violence-Act.pdf

Case study: Durban magistrate court: response and prevention

Instead of focusing exclusively on response and support, the Durban Magistrate Court Department of Domestic Violence and Sexual Offences expanded its prevention component.

Its work now includes cases in relation to its mandate around domestic violence and sexual offences, as well as information dissemination and awareness-raising campaigns.

During the Durban Local VEP Forum on 11 May 2012, stakeholders agreed that every department should consider further outreach and awareness campaigns.

Most of the victims who appear at the court have been referred from shelters and police stations. The court deals with a diversity of victims from all walks of life and races.

Significant insights:

- The number of sexual offences reported has been on the rise since 2011;
- Despite the rise in sexual offences and domestic violence cases, conviction rates remain low. The main reason cited is a high rate of case withdrawal; and
- The figures show that there has been a decrease in the number of sexual offenders registered. Despite this decrease, the incidence rate of sexual offences is said to be increasing.

Table 6.2: Number of sexual offenders 2011-2012

Year	2011	2012
Number of sexual offenders	27	25

Figure 6.11a: DV forms 2011

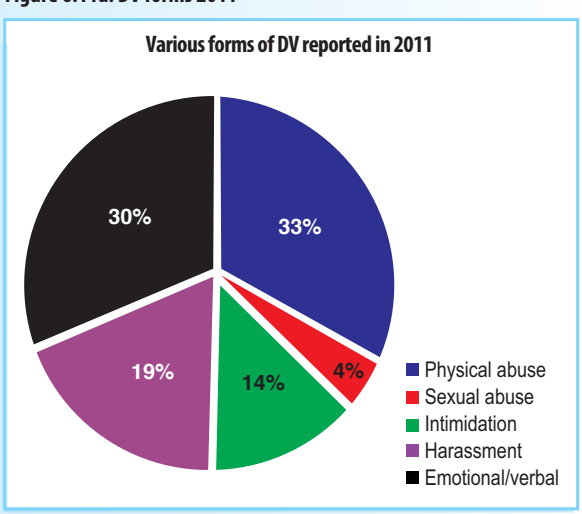
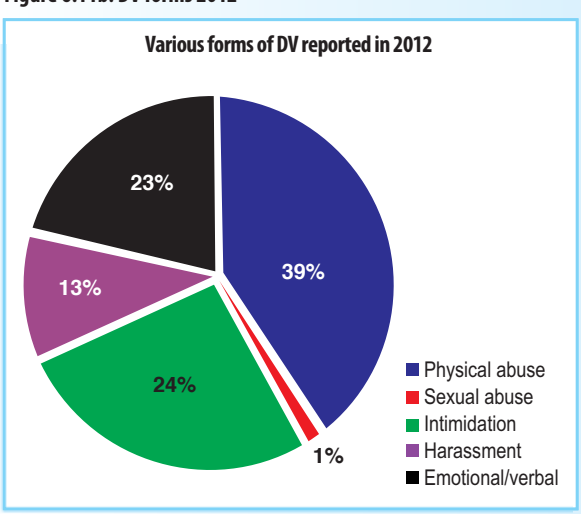


Figure 6.11b: DV forms 2012



Source: Durban Magistrate Court Report.

These figures illustrate that the most common forms of domestic violence offences reported at the courts include physical abuse, sexual abuse, intimidation, harassment and emotional and verbal abuse. In 2011, the judiciary mostly dealt with cases of physical abuse, followed by emotional abuse at 30%, harassment at 19%, intimidation at 14% and sexual abuse at 4%. The year 2012 saw slight changes. Physical abuse remained the leading form of abuse and rose to 39%, followed by intimidation at 24%, emotional abuse at 23%, harassment at 13% and sexual abuse at 1%.

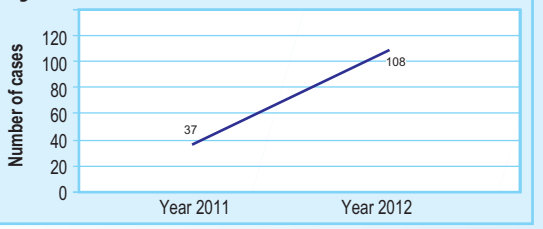
Table 6.3: Domestic violence applications in Durban

Applications	2011	2012
Received	3509	4041
Granted	1405	2321
Set aside	1718	2543
Warrant of arrest application	92	1541

Source: Durban Magistrate Court Report.

Table 6.3 illustrates that the number of applications received is almost double the number of applications granted. Also noteworthy is the number of cases set aside. Most cases had been set aside because applicants withdrew them.

Figure 6.12: Increase in number of convictions cases - 2011-2012



Source: Durban Magistrate Court Report.

Figure 6.12 shows that the number of convictions rose from 37 in 2011 to 108 in 2012. The increase is a sign of the improvement in how the province's justice system deals with cases of gender-based violence.

National Register for Sex Offenders (NRSO)

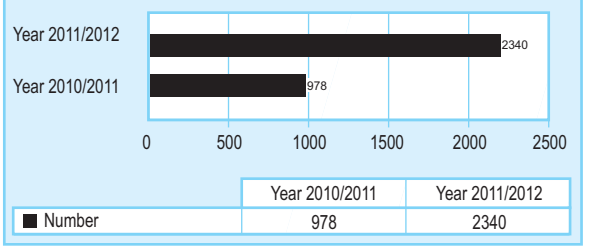
The National Register for Sex Offenders is a database containing particulars of persons convicted of any sexual offence against a child or a person who is mentally disabled. It also lists those alleged to have committed a sexual offence against a child and those who are mentally unstable but unfit to stand trial.

Its aim is to protect children and the mentally disabled against sexual offenders by establishing and maintaining a record of persons who have been convicted or alleged to have committed sexual offences.[60]

The number of registered names of sex offenders on the NRSO has increased in recent years, as illustrated by Figure 6.13.

Table 6.13 clearly shows a progressive increase of 139% in the registration of offenders. During 2011/12, the registrar received 39 684 purified names of historical convictions from the SAPS. This comprised the very first submission of historical convictions made to the Registrar and is therefore considered to be a huge breakthrough in the registration of this data. Unfortunately, the registrar did not receive data from other sources that had been identified (DOJ & CD annual report 2011-2012).

Figure 6.13: Number of registered sexual offenders



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

Conclusion

This chapter outlined the response structures that have been implemented to assist victims of GBV. As a nation, South Africa has shown its commitment to this issue by partaking in, and implementing, various international conventions that seek to protect the rights of women and combat GBV. Policies and legislation has been put in place in order to improve the country's response to gender-based violence. Two major policies - the Domestic Violence Act and Sexual Offences Act - directly address GBV by placing responsibilities on various departments, ensuring a holistic response system. However, it is evident that despite the existence of such policies, these actions have not yet translated into a decrease of gender-based violence in the country. The passage of such laws and policies has not been accompanied with adequate resource allocation for their effective implementation.

The major departments responsible for assisting victims of violence, namely the police, criminal justice, social services and health providers, have made significant strides in helping victims of GBV by establishing specialised structures. Policies and departmental victim friendly SOPs have been developed and used to positive effect, but in some instances victims have suffered from secondary victimisation because of poorly trained personnel at these centres. This reinforces the culture of silence among the victims. This study also highlighted the ongoing problem that many South African women remain ignorant of many of those laws which have been created to help them. Research showed that men seem to be more aware of the existing laws to protect women. This clearly shows that the current structures and measures do not adequately assist the main victims of violence.

CHAPTER 7
SUPPORT

Launch of the Rural Women's Association at the Conference of Parties (COP) 17 to the United Nations Framework Convention on Climate Change in Durban, South Africa.
Photo by Trevor Davies

Key facts

- Non-governmental organisations currently provide an estimated 60% of social welfare services for women and children.
- KZN has 13 registered shelters for victims of violence on the Department of Social Development's directory of facilities.
- The shelters in KZN receive their funding from the government through the KZN Department of Social Development (DSD).
- Umgeni Community Empowerment Centre is one of the few organisations that seek to provide a holistic victim support system which addresses their psycho-social, legal, safety and health needs.
- Open Door Crisis Care Centre runs a place of safety, facilitates support groups and offers counselling services for abused women in the Pinetown area.
- Esther House in Pietermaritzburg consists of safe houses and a crisis centre that is used mainly for overnight cases.
- The Advice Desk for the Abused is one of the oldest volunteer NGOs in South Africa that works to address the prevention of domestic violence and abuse in homes, communities and work places.
- Lifeline offers counselling services aimed at reducing personal stress and emotional pain through readily available counselling and growth programmes.

(My name is Lebo). "I never knew my parents. I grew up in a children's homes. The last children's home I was at is Harding in KZN. I stayed there when I was a teenager.

When I met my boyfriend, the father of my first child, he was working at the children's home as a caretaker. He approached me and I fell in love with him. We would see each other secretly without the knowledge of any house mothers at the children's home or any staff member. We dated for about five years while I was staying at the home. In 2010 I fell pregnant with his child. At that time I was almost 18 years old. The house mothers at the home noticed that I was not getting my periods at the same time I was gaining weight. They took me to the clinic for a check-up. At the clinic it was discovered that I was pregnant. The staff at the home asked me who the child's father was and I told them that it was Mongezi, the care taker at the home. We were both called to the offices of the home and he admitted that he was the father of my child.

Since he had admitted being the father of my child I thought he would take care of me and the child since I had nobody else and I had grown up as an orphan. When my 18th birthday came, I had to be placed somewhere with the child.

The child was moved to a Johannesburg children's home and I was referred to stay with another family in Howick, KZN. We were not getting along with the mother at that house and she said she can only take a child so I had to be moved to a shelter. I stayed at the Haven shelter for a year. I met a friend and we planned to get a job in Durban. We told the staff at the shelter that we were leaving and we got jobs in Durban.

Luckily, they let us move because they trusted us. In Durban we stayed together for awhile and we started working and everything was going well. Eventually we had a fight and my friend chased me out and I ended up staying with her sister. I then had a fight with her sister because I was not working at the time. Then I met my second boyfriend, a truck driver. I went to stay with him. I fell pregnant and told him but he denied that the baby was his, because he was staying together with his friend so, he suspected that I had slept with that friend of his.

He chased me out and I had nowhere to go. I told my friend that I was pregnant and she advised me to go back to the shelter. I came back to Pietermaritzburg to the Haven and I was so glad that they accepted me again. They have supported me and I have started the antenatal clinic. I am now seven months pregnant and my child's father is nowhere to be found. I have tried several times to call him and sometimes he would ask me to leave him alone. So now I am holding my breath because I do not know where I will I go if my time expires at the shelter. I also don't know what is going to happen to my baby. I want to keep this one because I lost the first one.

When this child is born, I want to have a paternity test with Emmanuel to prove that the child is his and I want him to pay maintenance for the child. I loved him but he gave me a child and whole lot of sexually transmitted diseases, then he left me."

Lebo grew up in a children's home and became pregnant at the age of 18. She is forced to leave the children's shelter and give up her child. She struggles before finding a shelter for women. When she leaves the women's shelter she moves in with friends. After the friendships turn sour she moves in with a boyfriend and becomes pregnant again. But her new boyfriend denies fathering her baby and abandons her. She has no option but to return to the shelter.

This chapter explores the adequacy, accessibility and effectiveness of support systems and structures implemented to respond to victims of GBV in KZN. This evaluation makes use of data from the prevalence and attitudes survey and administrative data provided by various GBV support organisations.

Definition of support

Support is one of the priority areas identified by the 365 Day National Action Plan of 2007. According to the NAP, support for victims comes in the form of

providing safe shelters as well as economic empowerment for the victims and survivors of violence. The plan recommends advocacy and lobbying on the links between GBV and economic development and also dialogues with relevant stakeholders in challenging the patriarchal system and its oppression of women.

Shelters

In some cases, a victim or survivor may be in need of a safe place to go after the incident. She may not be able to return to her home if, for example, the perpetrator is a member of the family, a neighbour or a member of her community.

The Minimum Standards on Shelters for Abused Women defines a shelter as:
A residential facility providing short term intervention for women and children in crisis. This intervention includes meeting basic needs as well as providing support, counselling and skills development.[61]

South Africa has implemented legislation and structures to promote the provision of shelters to victims and survivors of violence. Shelters for abused women can be categorised into three different stages namely:

First stage: this is short-term accommodation which 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.
Third stage: this is more secure and permanent housing that women move into after leaving the first and second stages.

Shelter services fall under the broader domain of the national government's Victim Empowerment Programme (VEP), a crucial component of South Africa's crime prevention strategy. The DVA stipulates that the SAPS should refer the victim of violence to a shelter or safe house if necessary. Although not specified by the DVA, the *Minimum Standards on Shelters for Abused Women* notes that responsibility to facilitate and fast track the provision of shelters for abused women, as well as ensuring the availability and accessibility of counselling services to women and children, falls under the Department of Social Development (DSD).[62]

Minimum Standards on Shelters for Abused Women

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

Other challenges related to provision of shelter services in South Africa include:

- Shortage of necessary facilities and human resources in the shelters: Some of the shelters do not meet the minimum standards stipulated by the DSD as well as the legitimate needs of the women and their children.
- Lack of psycho-social services for both the abused women and for their children.
- Breakdown of families in cases where the abused woman has male children older than 12 years of age. The psychological damage brought about by family separation cannot be over emphasised (TLAC, 2012).
- No provision of secondary shelters. As highlighted earlier, most shelters in South Africa offer first stage

[61] http://www.info.gov.za/view/DownloadFileAction?id=70651
[62] Expanding abused women's access to housing: handbook for shelter workers and domestic violence organisations. http://ipsis.uitm.edu.my/v1/images/stories/pdf/apahandbook.pdff/apahandbook.pdf

accommodation which ranges from three to six month, after which the survivors do not have anywhere else to go, especially when they are still not economically independent. This means many women have to return to their abusive partners. There is dire need to provide long term safe accommodation for women coming out of shelters.

Shelters for abused women in KZN

According to the National Directory on Services for Victims of Violence, KZN has 10 shelters for victims of violence, all of which are emergency facilities.[63] All the shelters in KZN receive 85% of their funding from the government through the KZN DSD. Other funders include the private sector.

Umgeni Community Empowerment Centre (UCEC)

The Umgeni Community Empowerment Centre (UCEC) is one of the few organisations in KZN that seeks to provide a holistic support system for victims that addresses their psycho-social, legal, safety and health needs. UCEC has adopted a multidisciplinary approach that has both short-term and long-term impacts. On a short term basis the UCEC provides shelter, toiletries and food packages to abused women in need. It also trains them with skills that have longer term effects for women survivors of violence. The approach also includes poverty eradication, which is a primary prevention strategy that seeks to empower women. Poverty, compounded by power imbalances, has been identified as one of the main triggers of GBV. The Centre also helps in building the victims' self-esteem. UCEC supports victims of abuse and empowers them in order to try to prevent a recurrence of GBV. The following case study elaborates on the various support services provided to GBV survivors.

Case study: Women find support at the Umgeni Community Empowerment Centre and the Shiloh House Crisis Centre

UCEC staff members employ a holistic approach to victims' rehabilitation.
Photo by Linda Musariri

Umgeni Community Empowerment Centre UCEC is an NGO that began in 2003 as a soup kitchen targeting school children and needy families. Seeking to address the various challenges faced by communities, the centre has grown to address other issues. Its primary focus is on the care, counselling, and rehabilitation of abused women and orphaned, abused, neglected or homeless children from marginalised communities.

The centre employs a holistic combination of programmes that meet the immediate and long-term needs of the victims. It works not only with victims but with women at high risk of abuse,

[63] http://lifelinedurban.org.za/

including street kids and sex workers. The centre aims to empower its clients and alleviate their risk by taking them off the streets and rehabilitating them before they face further victimisation.

Counselling ministry: On average 35 to 40 people visit the centre every day, each with different needs. The survivors share their stories with the newcomers. The centre provides receive counselling, food and toiletries. Counsellors assess clients to see if they require further counselling or other rehabilitation services. Counsellors also refer clients to shelts if necessary.

> *"Girls are not there because they want to... it's the circumstances they find themselves in that take them there."*
> Gloria, Director UCEC

Shiloh House Crisis Centre for abused women and children

The Crisis Centre is a safe house run by UCEC that provides temporary accommodation to abused women. It is situated in Berea, an area that is fairly central and allows beneficiaries staying there to easily commute to the UCEC offices. The shelter can only occupy 10 women at a time.

Programmes:

The following are programmes offered to survivors at the shelter:

Vukuzenzele "Get up and do it yourself" - basic skills training: The objective of this initiative is to design effective skills development programmes. The centre enlists the services of reputable service providers who assist in the pursuit of eradicating poverty and the cycle of unemployment. The centre strives to ensure the true empowerment of individuals through life skills development to ensure long term self-sustainability. Courses include basic computer skills, sewing and beading, kitchen skills and catering, community gardening and care-giving.

> *"There are so many people I have helped, some I don't even recognise them when they come back to thank me. I feel like it's a dream... that I have empowered a community. It is just seeing the joy on the faces of those people."*
> Gloria, Director UCEC

The Centre also helps abused women to develop CVs and prepare for job interviews. It also provides them with new clothing, including professional clothes they can wear to job interviews. The centre also helps individuals with personal issues that may undermine their employability, for example its staff members help women obtain personal ID if they do not have it. In some instances, centre staff members help women with grant applications.

Gloria de Gee, Director of UCEC attending to victims at the Centre.
Photo by Linda Musariri

Makeover: Every Wednesday is a makeover day. Women beneficiaries come into the centre to get haircuts, clothes, toiletries and even take showers. This helps to boost their confidence.

Siza HIV testing and counselling: This programme includes free voluntary counselling and confidential testing for HIV and AIDS as well as pre- and post-counselling, which is conducted by South African National Council on Alcoholism and Drug dependency (SANCA) every Tuesday at the centre's offices.

Institutional challenges

The centre relies entirely on donations and volunteers. It is short-staffed and has only one paid staff member: its secretary. All other staff members volunteer their time. The centre also does not have a vehicle it can use to purchase supplies and food stuffs for its beneficiaries.

Successes

Despite its challenges, the centre can boast of many success stories and achievements over the years. The centre has placed a multitude of people in rehabilitation centres and safe houses and assisted others to get grants and IDs.

Open Door Crisis Centre in Pinetown

Open Door Crisis Centre is another KZN NGO providing support services. Open Door Crisis Centre is a place of safety that facilitates support groups and offers counselling services for abused women in the Pinetown area. The following case study outlines its programmes, success and challenges.

Case Study: Opening doors for survivors of GBV

The Open Door Crisis Care Centre is a non-profit organisation established in 1997 at the request of the local South African Police Services. It aims to sustain a holistic, multifaceted one-stop crisis centre providing all required services for women and children victims of violence. This includes trauma counselling and psychosocial support, health care, police services, legal assistance, shelter services, to name a few.

Success stories: *Every day is a success story for the counsellors. Mpho, a counsellor at the centre, shared a story of a young girl who had been raped from the ages of five years to 12 years. This affected her self-esteem as well as her performance in school. She went through 10 sessions but she was still bitter and reserved and did not want to be part of the support group. After 10 sessions of counselling there has been a positive transformation in her life. She is now studying at UKZN and is a member of the support group. She has gained her confidence back and is now a happier young girl.*

Programmes

Place of safety

The Open Door shelter has capacity to accommodate 14 women at a given time. However, they have at times accommodated as many as 17 people. Women and children can stay up to three months. The shelter offers survivors food, toiletries and clothing. Its staff members carry out medical assessments and provide referrals. During the entire time a victim is at the shelter, Open Door empowers them to become independent and make the right decisions. This is achieved through counselling sessions, skills development (such as sewing and bead making) and life skills, including improving self-esteem, anger management, human trafficking awareness, CV writing, GBV and HIV awareness and entrepreneurship. The shelter also educates women about divorce and protection orders. It helps those women who choose to go back to their partner devise a safety plan and encouraged all women to keep attending counselling sessions, and in some cases to bring their partners along.

Support groups

Open Door facilitates support groups for survivors of rape, mostly those between the ages of 13-26. Support groups occur once a month, usually on the first Friday of the month. The shelter would like to hold more meetings like this but there is currently not enough money to provide transport for all the victims and survivors - some travel long distances to get to the shelter. During the support group discussions, survivors share their experiences and give each other advice and support. The sessions aim to take victims through the healing process so they can get to the point of forgiveness. The support group currently has 12 members.

Counselling and referrals

Following assessment, the centre refers victims to different sectors depending on their needs. This could include a health department, SAPS or another shelter. In cases of sexual abuse, those referred to the police may be taken to TCCs. Other counselling related activities include:

"The centre receives women from different races and backgrounds. When women are oppressed it is not a matter of colour but always about power dynamics."
Cynthia, senior counsellor

- Counselling with abused women, men and children;
- Trainings, including counselling courses every Saturday;
- Community outreach that involves counsellors going into communities to facilitate counselling sessions as requested;
- Call outs in companies for trauma debriefing;
- School visits that provide counselling to children; and
- Support groups in schools and communities.

Operational challenges

- Some of the victims who come for counselling face financial problems, hindering their ability to consistently attend counselling sessions. This impedes the healing process. This is also compounded by the fact that court dates are often far apart, which means they need a longer period of time to attend counselling.
- Another challenge is when a perpetrator gets bail and returns to the same community as the victim. This also affects the victim's healing process. In some instances the victim, rather than the perpetrator, is forced to leave the community. Many victims feel that the justice system has let them down, especially when police set perpetrators free.
- It is a challenge to communicate with deaf clients who use sign language as no one at the shelter understands sign language.
- The centre is still a small organisation with limited resources which makes it difficult to reach out to all those in need. The centre does not have transport to take victims to the police or to hospitals. It relies on police vehicles, which are not always available. When abused women come with their school-going children, the children often cannot attend their classes because there is no way to transport them to and from school.

Abrina Esther House

Abrina Esther House is a safe house and a crisis centre located in Pietermaritzburg. It is used mainly for overnight cases. An NGO runs the safe houses and provides support to abused women. The following case-study provides information about the organisation's background, programmes, challenges and successes.

Case study: Esther Abrina House provides short-term accommodation for victims of GBV

Background

Esther House began its operations in 2001 in order to offer safe, short-term accommodation for abused and vulnerable women and their children. It provides shelter for victims of rape, domestic violence, abuse and assault. The shelter's is to provide a safe space for women and children in distress until such a time as alternative accommodation can be arranged. The centre focuses mainly on providing support to victims of GBV.

Esther House consists of safe houses and a crisis centre that is used mainly for overnight cases. The safe house is registered to accommodate around 35 women, but at times the number rises to as many as 55. This puts a strain on the shelter's existing resources. One victim is supposed to stay for a maximum period of three months at the safe houses but many women end up staying much longer due to financial constraints. Some stay as long as one year.

Programme

Referrals

The shelter provides a supportive and morale-building home environment where staff members

provide wholesome meals for all residents. Working in partnership with other organisations, the house liaises with placing agencies, churches and organisations that can take responsibility for securing alternative accommodation for the women. The shelter also makes referrals to police, FAMSA, Lifeline, Childline, clinics and other departments. Victims also receive one-on-one sessions with a social worker as well as group therapy sessions.

Empowerment and prevention

The house has embarked on an empowering programme through which survivors receive skills training and development. These skills include housekeeping, hygiene, baking, sewing and crafting. The aim is to prevent a recurrence of GBV in the lives of the women who stay at the shelter.

Esther House staff members try to create a supportive environment for GBV survivors and their children. *Photo by Linda Musariri*

Organisational challenges

The house has six staff members including social workers, house mothers and care-givers. These staff members get stipends as there is not enough money to provide regular pay. The shelter has very few staff members for the large number of victims who pass through its doors. The shelter does not have enough money to pay for the human resources it needs. Not only is there a shortage in human resources but the shelter also lacks other resources. The shelter also sees a large number of difficult cases and uncooperative victims. Repeat cases have also proven to be a challenge because these victims tend to exist in a vicious cycle their partners.

The three shelter case studies presented in this chapter illustrate that stakeholders, civil society and concerned citizens have implemented measures for, and volunteer their time with, safe housing for abused women. However these case studies also presented institutional capacity and funding challenges that cannot be overlooked. These shelters all struggle to find enough staff and to pay staff. They also have all been hampered by a lack of resources, including vehicles, due to meagre budgets. It is also apparent that these institutions have a limited capacity to provide adequate housing. Other challenges include the need to deal with survivors who return after repeated abuse and inability to properly care for the children of survivors. All three, however, have seen success in referring survivors to appropriate follow-up service providers such as hospitals and the criminal justice system.

Counselling services

The implementation of the Domestic Violence Act (lead department: Justice) places responsibility on the government for ensuring the availability and accessibility of counselling services to women and children.

Case study: The University of KwaZulu-Natal Advice Desk for the Abused

The Advice Desk for the Abused, also known as "The Desk" is one of the oldest volunteer NGOs in South Africa that works to address the prevention of domestic violence and abuse in homes, communities and work places. The Desk has a head office at the Westville campus of UKZN. It also has offices at the Durban Magistrate Court, Verulam Court, Phoenix Regional DSD and Pinetown Court. The Desk offers support programmes and referrals for abused women.

Support programmes

Crisis intervention counselling: The Desk offers free face-to-face, telephone and on-site counselling. When a victim of abuse comes to share her story, counsellors at The Desk listen to the story and help empower the victim through counselling. In conjunction with courts in the eThekwini Metropole, The Desk offers counselling and advice at family courts.

Referrals: After an assessment, Desk counsellors refer women survivors to the courts so they can obtain a protection order. In some cases, Desk volunteers refer women to shelters or FAMSA. They also refer to partner organisations such as the Diakonia Church, Women in Action, Truth Movement of KZN, Foundation for Human Rights, Lawyers for Human Rights and the World Conference on Religion and Peace and the Department of Justice.

The main office for the UKZN's Advice Desk for the Abused is at the university's Westville campus. *Photo by Linda Musariri*

Prevention programmes

- *Short and medium range course within skills development and coaching framework:* The Desk conducts "train-the-trainer' sessions or three-day capacity-building workshops with CBOs, FBOs, students and members of the public. The Desk also runs programmes on learning to live without violence for perpetrators of abuse. It conducts other sessions to raise awareness in schools, prisons and work places. The Desk has also programmed these advocacy and awareness raising projects into its

calendar so they align with significant milestones and events in South Africa. Another of The Desk's strengths is its employment of primary prevention methods, such as engaging men in addressing GBV.

- *Research and knowledge management:* The Desk undertakes diagnosis and analysis within an action research paradigm in order to support people affected by abuse and inform the public and policy makers. A strong commitment to research guides its understanding of how to address and prevent GBV.
- *Brand ambassadors and corporate partnerships:* The Desk has also nurtured partnerships with various corporate organisations, such as Avalon.

Figure 7.1: Number of calls received including total cases, indirect queries and follow-ups in 2011

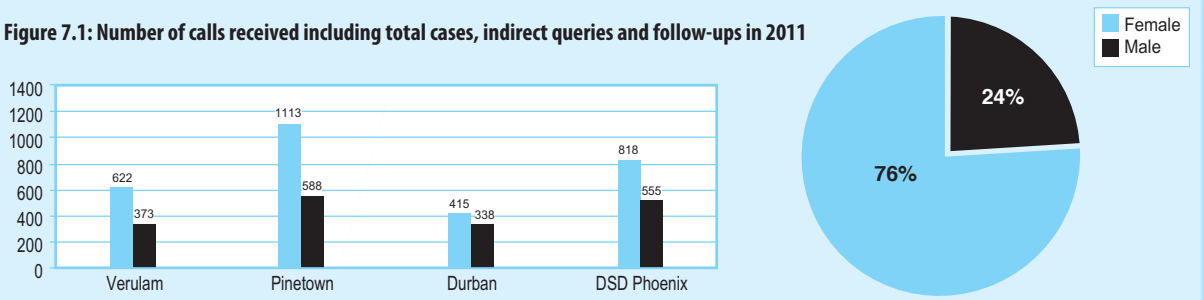


Figure 7.1 illustrates that the number of calls received from women is almost doubles the number of calls made by men, particularly at Verulam and Pinetown courts. The figure is slightly different in Durban, with only a few dozen more calls made by women. Women made 76% of the hotline calls received with-in the first half of 2011.

Table 7.1: Protection order applications per court

Court	Total calls	Court orders applied	Percentage
Verulam	1143	424	37
Durban	788	109	13.8
Pinetown	1701	874	51.4

Table 7.1 shows that the number of applications for protection orders is still low despite the high incidence rates of violence. The Durban court team received 788 calls, of which only 14% resulted in court orders. The Pinetown rate is relatively high, with slightly more than half having applied for court orders.

Challenges

The Desk's major challenge is financial: it could do more if it had more money. Desk staff members all volunteer their time (and get paid stipends) and there remains a limited number of staff to address a large amount of work. Most of the current staff members have retired from different professions, such as nursing and teaching. Despite the challenges they face, the Desk staff members remain driven by a passion to help others. The satisfaction obtained from giving a helping hand to those in desperate situations propels them to keep doing what they do.

> *"We are doing good work here, for me to be here for 17 years, life has been good to me and it is my turn to give back to the community."* Radha Naidoo, Director of the Advice Desk

Psycho-social support is an integral aspect of the provision of support for victims of violence. Regardless of the type of violence, it always leaves emotional scars. Psycho-social support helps facilitate the healing process.

LifeLine is a volunteer-based organisation that aims to reduce personal stress and emotional pain through readily available counselling and growth prog-rammes. Its counselling sessions normally tackle emotional crises, trauma, abuse, violence, relationships, youth-related issues, loneliness, illness and feelings of hurt, anger, frustration, rejection, disappointment and intentions of suicide.[64]

LifeLine
Building Community Heart

Case study: Throwing survivors a lifeline

LifeLine Durban

LifeLine Durban is an organisation offering counselling and support services. LifeLine works with hospitals to strengthen the services at hospital crisis centres. In 2011/2012 Life-Line worked in five crisis centres: Edendale TCC, Madadeni, Berville, Musinga and Estcourt.
(see the accompanying map)

Apart from counselling services, LifeLine also facilitates community dialogues in different settings. The main aim of this programme is to reduce incidents of GBV in different communities, especially in rural areas that uphold detrimental cultural practices such as ukhutwala. The programme is being implemented in uMsinga, Madadeni, Estcourt and Bergville. The programme is funded by FNB, Terre des Hommes and First for Women. The organisation has reached about 1300 community members through community dialogues in Msinga, Madadeni and Estcourt in 2011/2012.

Statistics

From 2011 to 2012 there has been a significant increase in the number of cases reported in the province. LifeLine attributes this increase to the impact of its community work in KwaZulu-Natal. During the same period, LifeLine reached 3617 men and 7353 women.

Table 7.2: Number of cases received at the crisis centres in 2011/2012

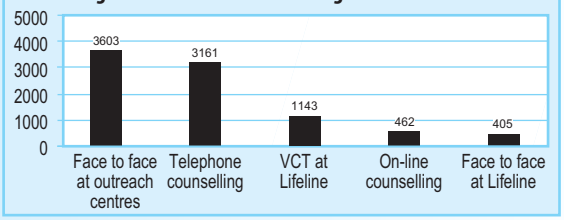
Site	Number of staff	Services	New cases	Received PEP
Edendale TCC		Counselling services to victims of rape and domestic violence	895	281
Madadeni Hospital		Court preparation, PEP administration, community dialogues	984	
Bergville project, Emmaus Hospital	Two counsellors, one community field worker, several trainees	on GBV-related issues, ukhutwala awareness, HIV and AIDS counselling, IEC talks in schools, community and OPD.	23	
Msinga, Church of Scotland Hospital	One coordinator, two counsellors			
Estcourt Hospital	Two counsellors		178	160

Source: Life Line Annual Report 2012.

[64] http://lifelinedurban.org.za/

Table 7.2 illustrates the number of cases received and the services offered in the various sites. Majority of the new cases were received in Madadeni Hospital and the least number was recorded in Emmaus Hospital. Overall, the organisation counselled 10 970 people from March 2011 to February 2012. Of these, women who had been abused by a partner comprised 4 507 (37%) cases, followed by (1434) 13% cases of child sexual abuse and 1123 (10%) cases of rape. These figures show that most cases of violence occur within the domestic sphere. Figure 7.2 illustrates the various means LifeLine uses to reach out to victims.

Figure 7.2: Cases reached through different means



Source: Life Line Annual Report 2012.

Figure 7.2 illustrates the total numbers of LifeLine cases and the various ways it dealt with them. It assisted more than 3500 victims through face-to-face counselling sessions at its different outreach centres. It also reached more than 3000 people with telephone counselling. More than 1000 people visited the VCT at LifeLine and 462 people accessed online counselling.

LifeLine continues to make a difference in the lives of victims by providing much needed psycho-social support. Effective psychosocial support for survivors does not only mean the delivery of direct one-on-one response services such as counselling.[65] It must instead holistically meet the needs of women and children while also adopting measures to reduce their risk of violence. It is evident that LifeLine has mastered this concept because in addition to its counselling services it also conducts awareness programmes, provides legal assistance and provides PEP to survivors of rape. LifeLine has also integrated its services within already existing hospital structures, including TCCs providing assistance to victims of violence.

The Stop Gender Violence Helpline

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

The helpline provides an empowering counselling environment to GBV survivors. It gives callers accurate GBV information to facilitate a continuum of care. It also provides referrals.

NICRO Perpetrators of Intimate Partner Violence Programme

The Perpetrator of Intimate Partner Violence (PIPV) programme is a domestic violence intervention that focuses on the offender, the victim and the family. The intervention aims to reduce or eliminate the occurrence of domestic violence through exploring the cycle of violence and the effects of violence on the family. The intervention is based on individual counselling that involves both the offender and the victim and informs them on how to deal with protection orders

[65] http://www.gbv.ie/wp-content/uploads/2007/12/118-providing-effective-psychosocial-support-for-survivors-of-gender-based-violence.doc

and safety plans. The programme also includes anger and conflict management programmes. PIPV consists of 30 sessions that run over 16 weeks, with each session lasting one to three hours.

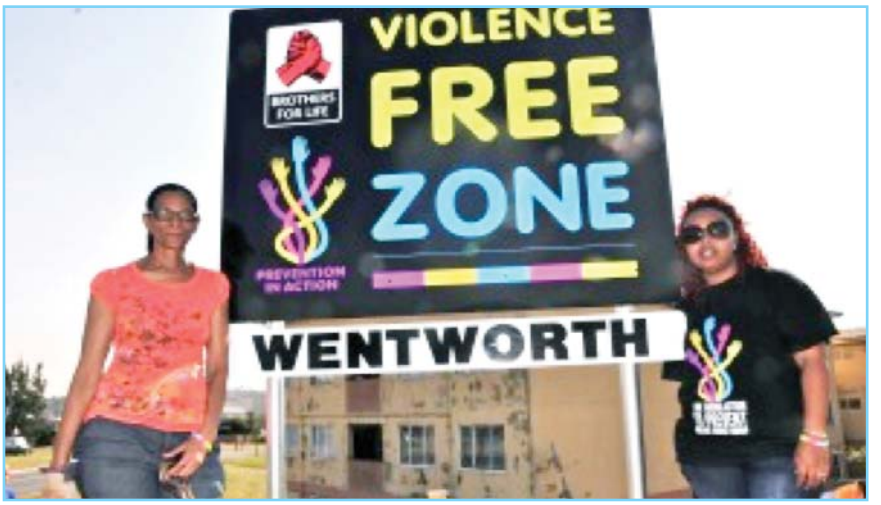
Conclusion

This chapter has illustrated that victims of GBV in KZN can access support in a variety of different ways, including at safe houses and shelters. They can also access psychosocial support. South Africa has taken significant strides in promoting the provision of shelters to victims and survivors of violence as evidenced by the strong policy frameworks that exist.

However, despite these frameworks, challenges exist in implementation and funding for shelters. Not enough shelters exist in KZN province - and in the country at large - to address the overwhelming need, and many shelters frequently house more women than they can handle. Shelters coordinated by NGOs face huge funding shortages and instability due to lack of funding. This often adversely affects the women and children these shelters have been set up to serve. Lack of money also threatens the sustainability of such operations.

Legislation on standards for governing shelter registration is yet to be finalised, which means it is difficult for the DSD to monitor shelters against any minimum standards. The quality of care in shelters is also compromised because shelters cannot retain staff members; instead they often rely exclusively on volunteer labour. Research has shown that the majority of shelters face serious financial constraints and understaffing. The case studies in this chapter illustrate the variety of services offered to victims of violence. This includes psychosocial support, economic empowerment and legal assistance. The specifics vary from shelter to shelter but a lack of funding and support is a common theme in every case study. It is noteworthy that these case studies show that much of the support to victims of violence is being facilitated by the civil society. Many of these facilities face similar challenges, including inability to provide adequate housing, repeat visits from survivors who return to abusive homes and challenges dealing with transportation and children of survivors. Worth noting, however, is that despite these challenges, the case studies presented here illustrate a resolute commitment on the part of service providers to ensure survivors can get referrals to other vital services and to the criminal justice system.

CHAPTER 8
PREVENTION



Wentworth residents launch Violence Free Zone, KZN, 2012. *Photo courtesy Google Images*

Key facts

- The government showed its commitment to addressing GBV by allocating R16 million toward the national VEP in the financial year 2013/ 2014.
- Only 5% of women and 83% of men have heard of the 16 Days of Activism.
- Three percent of women and 16% of men knew of the 365 Days campaign.
- Most women (38%) heard about the GBV campaigns through television or radio (32%).
- Almost half the men heard about the campaigns through radio, while 20% found out about them in a newspaper and 16% from television.
- "Don't look away" is the most well known slogan among women (32%), while men easily associate the slogan "Real men don't abuse women" with GBV campaigns.
- Almost equal proportions of men (29%) and women (27%) link the slogan "Peace begins at home" with GBV campaigns, followed by "Act against abuse" (12% women and 15% men).
- The Durban magistrate court has moved beyond its judicial mandate to get involved with communities in raising awareness about GBV.
- 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 Statement 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 (Nolwazi) never knew my real father and I never had a father figure until I was 13. That's when I was introduced to my step dad and his family. We were a happy small family and then I met my boyfriend, Phaphani, who was older than me.

We dated for a month and he wanted to have sex. I told him I was not ready and he understood for some time. Again he wanted sex; I told him that I was not ready. He told me that he had waited long enough and he couldn't wait anymore. After sex he told me that I was his girl and no one else's. After that he introduced me to his mom and his brothers. I started to spend time with them, then my family found out and they didn't like him at all. My mother asked me to break up with him but I didn't listen. However, with time my boyfriend changed. He would force me to go to his home whenever he wanted, no matter what time it was. One day I refused to go and he started hitting me so hard that my eyes were red with blood from the inside, when I told him that I wanted to go home, he said that I couldn't because my mom and dad would see what he had done and would have him arrested. So I had to stay there for two days and then I went home. My dad did not like it - he told me to break up with him or else he would kick me out of the house. I did not do that, in fact I carried on in the relationship because he always came to my home and asked me to go with him. I then went away for a weekend without telling Phaphani. When I got back he hit me over and over again, when I asked him what I have done he told me that I disrespected him for not telling him that I was going away for the weekend.

At school he asked a guard to watch me and report to him everything I was doing. If I spoke to a boy he would come home and take me outside and beat me until I apologised and told him that I would never do it again. My father was tired of what was happening so he kicked me out. I told my boyfriend that I was kicked out and he told me to stay with him. I moved in with him. When I was staying with him things got worse; he would leave me in the house every Friday in the morning and come back at midnight smelling of booze. He would want to have sex and if I refused he would make up a story so that he would hit me for not sleeping with him. At night he would want to touch me and have sex by force, when I screamed he would increase the volume of the radio so that nobody would hear me. If I fought with him he would take out his knife and threaten me with it. After the fight in the morning he would apologise and do a special thing for me, trying to make up for what he did, he would tell me that it was not his fault and I should not disagree with him - when he wants sex, I should always give it to him because I am his girl. He carried on doing it and going away for two days and then coming back drunk and expecting sex from me.

One day he came again trying to do the same thing and I told him I wanted to go home. We had a fight about that and he tried to hit me. I ducked and ran away but he came after me, caught up with me and took me back to his room where he strangled me until I was out of breath. He saw that I was not moving or doing anything and he let go and tried to wake me up. When I woke up I couldn't do anything. I couldn't even speak. He then tried to bath me and put me to bed. The day after I asked to go to the clinic but he refused and told me he would be arrested if I went there. After that I went to school and my friends saw the bruises and nail marks in my neck and told me to go to the police but I was scared. I thought it was my own fault that it had happened to me. I carried on staying with him. I did not speak to him for two days. I then went home to apologise and try and go back and stay with my family but my aunt and uncle refused. I was tired of staying with Phaphani and I wanted to go back home but I couldn't. One day I went to a school prayer without telling him and I came back late. He was so mad that he started to hit me for three hours. He then hit me with the flat part of a bush knife. My whole back was full of bruises and scars and I couldn't move.

The following day I went to talk to my mother and she saw that I was limping on my right leg and she asked what happened. I told her and she told me to go to the police. I told her that I was scared because he told me if I went to the police he would kill me. He never wanted me to see my baby, nor even talk about him. I was so tired I decided to run away, but before I ran away I had to break up with him. Every time I

broke up with him he would hit me until I apologised. I eventually told him and he said if I did not want to come back I shouldn't, because he didn't care anymore and also didn't want me. That day I went to my cousin's place from school. At night his friends came over there and told my cousin that he wants me back. I told her to tell them that I'm not coming back to him, not after what he had done to me. Then he started following and begging me to reconcile with him.

I went to see a social worker who told me to go to the police to make a peace order against him. When he got the papers he did not like it he said he would kill me. He followed me around and if it wasn't him it would be his friends. He said he would not rest until he found me. But then the police told him if he kept on following me he would go to jail. He stopped for a bit then he started again. When we met he told me to drop the case or I will die but I decided to change the place where I was living. I am now living happily with my child."

Nolwazi's story highlights the plight of many young girls in South Africa. She is a school-going girl who also has a child. She gets involved with a possessive and abusive boyfriend who beats and rapes her on a regular basis. Despite having been told by her parents to leave this man she continues seeing him. She is even advised to report him to the police, but she is scared he may hurt her. Eventually, when she decides to leave him, he threatens to kill her. However, one day she gathers the courage and leaves the abusive relationship. She even gets a protection order against the man and her life improves.

Violence prevention programmes need to be holistic and build on evidence, targeting those at risk (primary prevention) or those who have been victims or offenders. This helps reduce re-victimisation or re-offending (secondary prevention). The above story illustrates that school-age girls can be susceptible to GBV, which means prevention programmes should also target them. Girls like Nolwazi need to be aware of GBV so they can avoid abusive relationships. Engaging school boys from a young age is another way of preventing GBV. This chapter highlights some of the strategies that can be used to prevent GBV.

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

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

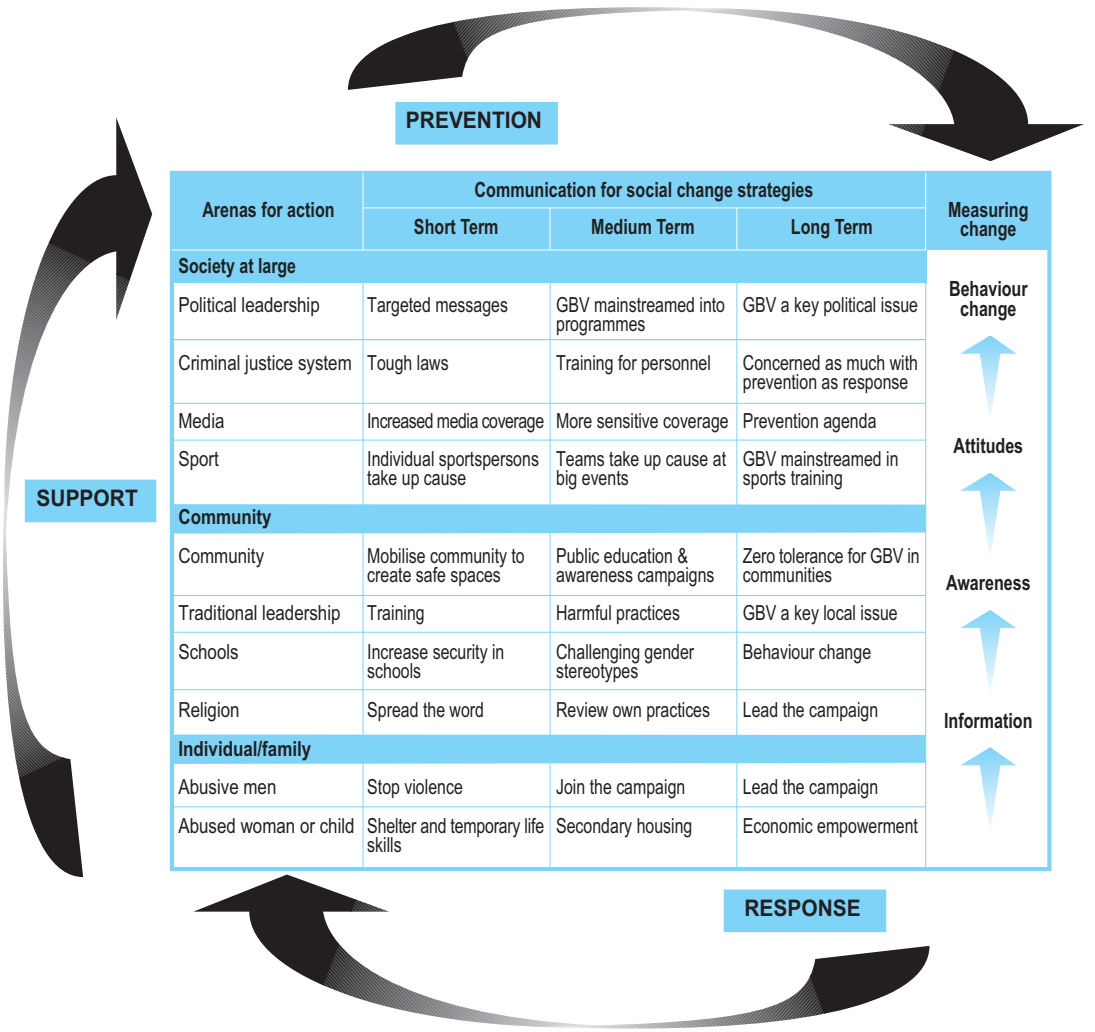
Secondary prevention happens immediately after violence has occurred to deal with the short term consequences, for example treatment and counselling. GBV survivors require comprehensive care and support from multiple service providers. This includes health, legal, social services, education, economic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

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

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

Figure 8.1: GBV Prevention Model

NATIONAL CAMPAIGN: 365 DAYS OF ACTION TO END GBV



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	
Sport	Individual sportspersons take up cause	Teams take up cause at big events	GBV mainstreamed in sports training	Attitudes
Community				
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	Awareness
Religion	Spread the word	Review own practices	Lead the campaign	
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	Information

Figure 8.1[66] identifies a number of "arenas" in which GBV is reinforced or can be challenged. These include 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.

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

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 victimi-sation. Working in unison, prevention, response and support strategies can both reduce GBV and ensure redress for those affected.

- *Stepping up targeted primary prevention interventions at three key levels:* In the home (women, men, children and the family); the community (traditional leaders, religion, schools and sports); and the broader society (the criminal justice system, media and political leadership). Again, if well designed, these initiatives should form a continuum. An initiative to empower abused women should also seek to change the way that their families, communities and society address GBV and vice versa.

- *Identifying approaches and strategies that work* based on communication for social change theories and using these in the design of future interventions.

- *Developing more effective monitoring and evaluation tools,* bearing in mind that up to now most of the data available concerns ***outputs*** rather than ***outcomes***. Ultimately, prevention campaigns must be able to demonstrate that their impact moves beyond information and awareness to create knowledge, wisdom and behaviour change. This in turn should lead to a quantifiable reduction in GBV.

Areas for action

The ecological model locates key arenas for action:

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

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

Political will and commitment to address GBV

For a violence prevention strategy to be successful it has to be unified, coordinated, scientifically-informed, well-resourced and directed across all clusters of society, government departments and civil society. The most effective way to fight violence against women is a clear demonstration of political commitment by states, backed by action and resources.

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 through the Inter-Ministerial Committee for Anti-violence against women and children, in partnership with non-governmental organisations that work in the area of gender-based violence and women abuse. The government is expected to devise an effective strategy that will address most of the gaps and weaknesses in the current system. The new strategy should ensure greater effectiveness of the entire criminal justice system. It will target men and boys with a view to tackling harmful gender stereotypes and cultural practices that condone violence against women. The government has also shown its commitment in addressing GBV, allocating a total amount of R16 million towards the VEP in the financial year 2013/ 2014.

Case Study - Mobilising Communities to create a safer KZN

KZN Department of Community Safety and Liaison

The department is the lead agency in driving the integration of community safety initiatives towards a crime-free KwaZulu-Natal. Its vision is: "The people of KwaZulu-Natal live in a safe and secure environment."

The department is fulfilling its mission through different initiatives including:

1. Creating awareness of protective rights for children in partnership with various stakeholders through the utilisation of the comic book and DVD series called Kuyoze Kubenini. Programmes include child protection awareness campaigns, road shows and domestic violence bus campaigns.

2. The department has an overall programme for all activities associated with victim empowerment called Operation Khuz'umhlola. It means: reprimand unacceptable behaviour. Programmes cover the widowed, women, children, men, human trafficking and 16 Days of Activism on No Violence Against Women and Children. Awareness of protective rights for women has been promoted through hosting women's domestic violence dialogues and DVD road shows.

3. In partnership with the National Prosecuting Authority, the department conducted capacity-building workshops in nine districts for the SAPS and the community. The workshop topics included gender-based violence, the Sexual Offences Act and the Domestic Violence Act.

4. The department has been paying specific attention to the area of Umzimkhulu after its incorporation into KwaZulu-Natal from the Eastern Cape. It implemented the following projects: resuscitation of CPF structures at Ibisi, Gowan Lea, Intsikeni and Umzimkhulu police stations; awareness campaigns on substance abuse and school safety; training of Volunteer Social Crime Prevention Project (VSCPP) members on trauma debriefing, effective management of domestic violence and victim

empowerment cases; and inclusion of Umzimkhulu delegates in traditional leadership training on crime prevention.

5. The primary goal of the traditional leadership capacity-building programme is to encourage traditional leaders to contribute towards the strengthening of families, thereby contributing to moral regeneration. The department sees this as a prerequisite for producing resilient citizens and contributing to stability in communities. The programme encourages traditional leaders to be actively involved in community safety structures within their area. This is done in the form of three-day capacity-building workshops for Amakhosi and members of traditional councils conducted.
6. Following the launch of Operation Hlasela in March 2011, the department implemented various initiatives. These include: the prevention of conflicts resulting from stock theft, training on the Pound Act, Sexual Offences Act, Domestic Violence Act and Human Trafficking Act.
7. The Department is responsible for promoting good relations and establishing partnerships between the police and communities. In March 2012 the department reconstituted the Provincial Community Policing Forum Board (CPF). Since then activities have included 39 CPF induction workshops for newly elected CPF and youth desk members.

Adapted from the KZNDCSL Annual Report 2011-2012

National Public awareness campaigns: 16 days of Activism campaign

Level of action: individual and community

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

Key dates include:

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

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

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

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

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

The vision of the government, and recommendations and findings of the 10 Year Social Impact Assessment, largely informed the objectives for the 2012 campaign, which called for:

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

Awareness of and participation in national campaigns

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

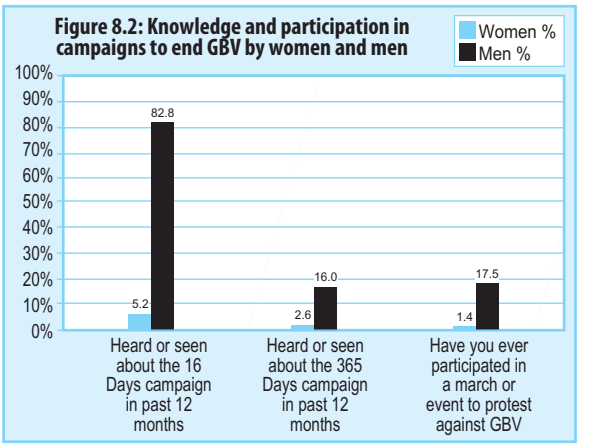


Figure 8.2 shows that women and men in KZN province remain relatively unaware of GBV campaigns. However, the most glaring difference between men and women is knowledge of the 16 Days of Activism campaign, which only 5% of women knew about it. Meanwhile, a much higher number of men (83%) knew of it. Such a difference is a cause for concern. An even lower proportion of women (3%) and men (16%) knew of the 365 Days campaign. One percent of women and 18% of men had participated in a march or event to protest against GBV. Although these figures show that men seem to be more aware of campaigns than women, general awareness about these campaigns is low. These findings indicate that there is likely unequal access to campaign information. Men in KZN seem to have more access to information about campaigns and greater ability to participate in GBV events. These findings point to a need for greater outreach efforts, especially geared toward women.

Source of information of events or GBV awareness campaigns

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

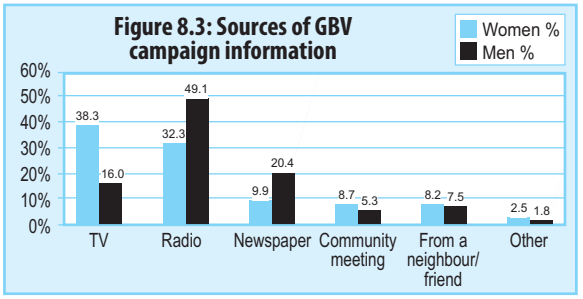
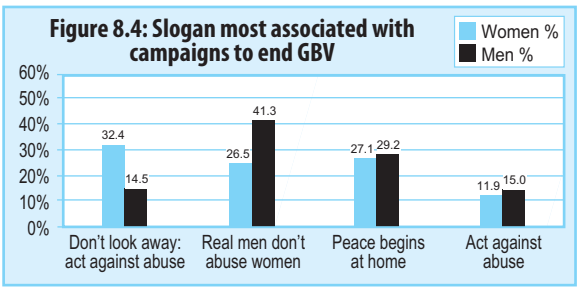


Figure 8.3 shows that the majority of women (38%) heard about GBV campaigns on television (38%) or radio (32%). Some women also got their information from newspapers (10%), community meetings (9%), friends (8%) and other sources (3%). Men on the other hand exhibit a different trend; almost half the men heard about the campaigns on the radio. Twenty percent learned about them in a newspaper, 16% on TV, 8% from friends, 5% at a community meeting and 2% from other sources.

It is interesting to note the differences between men and women in terms of access to information. While television is the most common medium used to access information for women, greater proportions of men access information from radio and newspaper. In contrast, only a few women access information from newspapers.

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

Figure 8.4 illustrates that "Don't look away" is the most well-known slogan among women (32%). Meanwhile, a majority of men easily associate the slogan "real men don't abuse women" with GBV campaigns. Almost equal proportions of men (29%) and women (27%) link the slogan "Peace begins at home" with GBV campaigns, followed by "Act against abuse" (12% women and 15% men).



Community mobilisation

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

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

Researchers have undertaken several studies in KZN to assess the effectiveness of community mobilisation as a tool for change. One case study from Project Concern International is outlined below.

Case study: Harnessing communities to fight GBV

Prevention in Action (PIA)

Lessons learned and a model for social mobilisation to address violence against women in South Africa

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

The programme aimed to reduce the prevalence of physical and sexual violence against those women most vulnerable to HIV infection in KZN and the WC. In 2009, researchers conducted a baseline study. They discovered that most respondents knew that GBV is wrong. Despite this, the research found GBV to be pervasive. For this reason researchers focused the project on changing another norm, inaction, and attempted to encourage communities to act to prevent GBV.

Creative Consulting & Development Works (CC&DW) evaluated the PIA programme using a predominantly qualitative evaluation design. They used secondary data for quantitative analysis. Researchers conducted a final study at the end of the four years to understand how the PIA programme had fostered deeper understanding in the strategies to prevent GBV.

An analysis of 2,429 action narratives documented by the programme over an 18-month period informed understanding of the transition from inaction to action in engaging with GBV. The programmed addressed a fair proportion of severe violence and led to police involvement or other legal processes being followed. According to the narratives, the programmed helped resolve almost half (48%) of the cases 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% improved community safety.

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

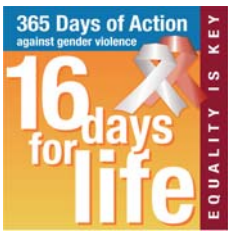
Durban Magistrate Court: Prevention through awareness campaigns

Having noted the effectiveness of engaging communities, the Durban magistrate court has moved beyond its judicial mandate to also involve communities in raising awareness on GBV. Instead of only playing a responsive role in addressing GBV, the court has carved out a role in prevention.

Apart from offering judicial support, the court also holds outreach campaigns to raise awareness on violence against women and children. It holds these in collaboration with the communities and other government departments and NGOs that focus on domestic violence. The court also has an advice desk where it sends some victims for counselling and referrals.

At times court staffers hold discussions in communities where violence against women is rife or communities where known perpetrators live. The court also raises awareness about the Sexual Offences Act in schools once every quarter.

16 Days of Activism



The court joins arms with other organisations in raising awareness during the 16 Days of Activism campaign. Usually during this period every staff member participates in the events carried out. The group also holds awareness raising campaigns in public places such as taxi ranks, schools and churches as requested by community members. The court also holds sexual offences and domestic violence forums. These take the form of information sessions where different stake-holders can share information and their thoughts on various issues pertaining to domestic violence. During these forums the organisers circulate information about the campaign.

Achievements

The national office requested that there be a waiting room for domestic violence applicants. This waiting room is designed to disseminate important information to victims of violence as well as help them deal with their situation. At the moment the waiting room is under renovation.

The 14 February campaign

On 14 February 2013, many people attended an event hosted in front of the court by the Diakonia Council of Churches. They planted flowers and delivered a message about violence against women.

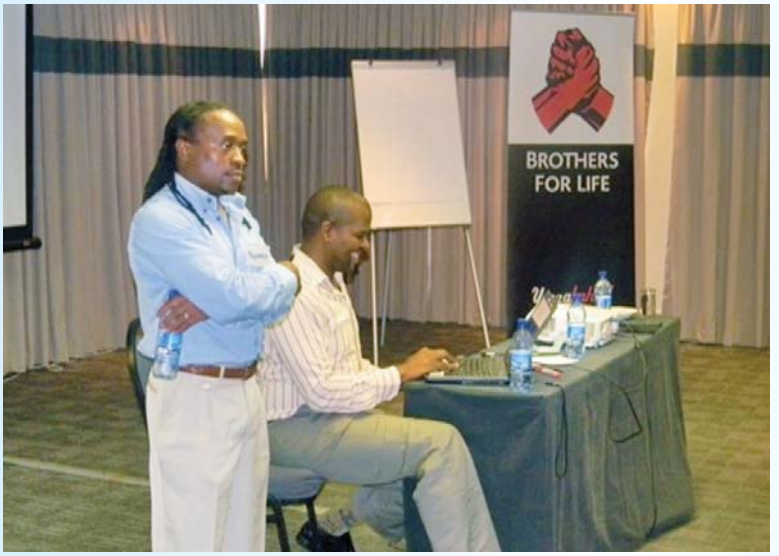
Working with men

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

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

A significant number of organisations engage men in the fight against gender inequality in KZN. Honig (2007) undertook a study to assess some of these programmes in KZN. These are: Men as Partners, a project undertaken by Hope Worldwide, and the One Man Can project championed by Sonke Gender Justice Network.

Involving the Other Gender: A Case Study of the Men As Partners Program in Kwazulu-Natal



Men in KwaZulu-Natal drive the Brothers For Life Campaign. *Photo http://www.brothersforlife.org*

A 2007 study assessed the initiatives of the Men as Partners (MAP) programme carried out by Sonke Gender Justice Network in Nkandla, and Hope Worldwide in Durban. It sought to establish if working with men is a solution to ending violence against women or just another attempt to change the unchangeable. Research methods included interviews with project directors, workshop facilitators and key community leaders. Researchers obtained informal qualitative data through interaction with workshop participants.

MAP is able to see the change in attitudes through the pre- and post-questionnaires. Despite the fact that these workshops have proven to be effective in many ways, the focus still needs to widen from workshops to dealing with underlying issues of poverty and social inequality. The study also discovered that there is an "overreliance on workshops and one-off campaigns" like the "16 Days of Activism." Thus there is need to move from once-off events to longer term interventions. The study also argues that since the perpetrators of GBV remain overwhelmingly male there is need to incorporate programmes that challenge their thinking within the nation's agenda of promoting gender equality.

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 an object of criticism over the years as some feminists argue "how can a man tell a woman's story?" (National Organisation for Men against Sexism, 2008). While this may be the case, 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 GBV.

The KZN Advice Desk for engaging men

The Advice Desk is a good example of an organisation that employs a wide array of strategies to respond to GBV in communities throughout KZN. Not only does it work with men and engage the perpetrators with the aim of preventing recurrence of domestic violence, it also offers support to victims. While involving men contributes to the primary prevention of GBV, the Advice Desk also engages in other activities that involve community members. These include sector partnerships, capacity-building, communications strategies, research and community-level activities which have all contributed to the Desk's sustained response to address GBV. Some of the activities are outlined in detail in the accompanying case study.

Case study: Becoming a real man

The KZN Advice Desk works with men to address GBV. The project is called the Real Man or Indoda Eqotho campaign. The group launched it in 2007, inspired by the idea that real men can and will be part of the solution to stopping violence and abuse in communities.

The campaign's most visible resource is a cap with the campaign's slogan which has been distributed widely in the province. The campaign attempts to address the serious scourge of abuse being carried out, particularly by male perpetrators. Its message is that a real man will stop violence by committing to not becoming an abuser himself. He will also stop violence by stopping other men being violent. The campaign is supported by Danny K, a South African musician, and AB Moosa, a prominent business personality.

Education

The education system is also instrumental to stopping GBV before it starts. Regular curricula updates, sexuality education, school counselling programmes and school health services can all convey the message that violence is wrong and can be prevented. These tools can also suggest alternative models of masculinity, teach conflict-resolution skills, and provide assistance to children and adolescents who may be victims or perpetrators of violence. Integrating GBV 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 8.1: 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.

GBV and the media

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

Secondary prevention

Secondary prevention takes place immediately after the violent event occurs and includes steps which decrease the likelihood of the event reoccurring.

Health personnel training

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

Development of materials by the Department of Justice and Constitutional Development

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

Trainings around SOA by Department of Justice and Constitutional Development

In the financial year 2011-2012, NPA SOCA conducted multidisciplinary training on the investigation and prosecutions of sexual offences cases. The training courses included advanced skills on prosecuting child sex offenders, child pornography training seminars and integrated training for case managers, victim assistance officers, site coordinators and relevant stakeholders involved in TCCs and SOCs. The department also developed the training manual on criminal law (sexual offences and related matters) Amendment Act 32 of 2007. The department conducted subsequent training for 645 prosecutors in 23 training sessions in all provinces. Court personnel received training on issues pertaining to sexual offences and domestic violence. All in all, the department conducted 461 sexual offences and 227 domestic violence trainings nationally (DOJ & CD annual report 2011-2012).

Trainings around DVA by the Department of Justice and Constitutional Development

In 2011-2012 the SOCA team delivered five training sessions on the Domestic Violence Act attended by 108 prosecutors.[67] The SOCA also established a partnership with information and systems management in the DoJCD National Operations Centre (NOC) to develop an electronic and standardised case management system for domestic violence matters specifically in relation to protection orders, but also those offences linked to GBV.

The department's Justice College has dedicated training programmes for clerks and prosecutors. The South African Judicial Education Institute is training the judiciary in matters relating to domestic violence. The DoJCD, in partnership with NPA, also implements training on the Family Law Practice Learnership: SAQA Qualification No. 50265, which carries three Unit Standards for Domestic Violence, having a total of 32 credits.

Table 8.2: 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: DoJCD annual report 2012[68]

[67] http://www.npa.gov.za/UploadedFiles/NPA%20Annual%20Report%202011-12%20Final%20Copy.pdf
[68] http://www.pmg.org.za/print/report/20120215-department-justice-constitutional-development-implementation-domestic

Table 8.2 illustrates that in 2011-2012 the Justice College also conducted training programmes for court officials.

NPA also conducts multi-disciplinary training through the Integrated Domestic Violence Training Programme. The programme covers all the roles of stakeholders within the domestic violence sector.

Forty-five delegates, including doctors, advocates and investigators, attended the technical assistance training programme in March 2011 in Maputo.[69]

Case study: The Zivikele campaign

Zivikele empowers communities in combating all forms of gender-based violence and through strategic advocacy and lobbying contributes to the ongoing battle against GBV and HIV and AIDS.

Photo http://www.zivikele.org.za/

Activities

Zivikele's core activities include:

- Advocacy and lobbying with key stakeholders and role-players in public sector and NGO sectors;
- Training of service providers at first point of response to address GBV and HIV and AIDS in traditional leadership, government departments, and civil society;
- Providing and maintaining a GBV and HIV and AIDS online database of service providers who manage clients of human rights abuse, GBV and HIV and AIDS;
- Contributing to policy and legislative change to address and mainstream the needs of vulnerable groups through further advocacy and lobbying.

Achievements

- Zivikele has successfully trained 23 SAPS skills development facilitators and assessors from throughout KZN in Skills Education Training Authorities (SETA)-accredited unit standard-based training courses. Zivikele conducted these sessions in collaboration with the provinces' 2011-2012 theme of Operation Hlasela: Fighting Crime - A Better Vision for Service Delivery, launched by the KZN MEC of Transport, Safety and Security Willies Mchunu. Zivikele received special mention at the annual KZN police award ceremony as outstanding service provider to the province.
- Under the direction of the Safety and Security MEC, Zivikele, together with technical experts from KZN SAPS and community safety and liaison, established a provincial monitoring and evaluation tool for police stations and introduced GBV law enforcement training material, a first among the nine provinces.
- Zivikele has worked hard in its advocacy campaigns to influence government policy, strategy and certain laws relating to sexual offences and gender-based violence.

[69] http://www.justice.gov.za/VC/events/2012natconf/paper_npa.pdf

Trainings by the SAPS

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

During 2011-2012, SAPS participated in a regional training workshop with the United Nations Office on the Drugs and Crime (UNODC), which is a coordinator of the development of effective law enforcement and responses to violence against women in the Southern Africa region, particularly domestic violence. It also presented the Violence against Women and Children course to the Southern African Regional Police Chiefs Cooperation (SARPCCO) task team at a work session in Pretoria. This session illustrates part of the SAPS and South African government's commitment to assist the SADC in addressing GBV within the region.

Given the sensitivity of issues relating to GBV, especially violence against women and children, the SAPS has taken measures to ensure the availability of adequate and properly trained personnel to deal with issues of violence against women and children.

Figure 8.5: Personnel trained on the DVA and SOA

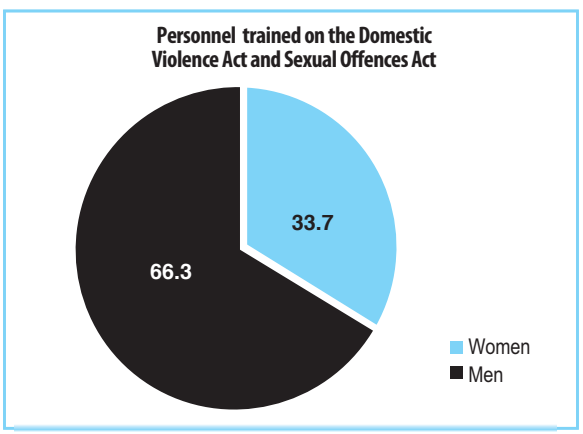


Figure 8.5 shows that in KwaZulu-Natal, women comprise 34% of those SAPS staff members who received the basic training on the Domestic Violence Act and Sexual Offences Act by January 2012. Men form the majority of those trained on the Domestic Violence Act. This shows that SAPS still needs to enrol and train more female officers who can take statements and investigate highly sensitive matters that involve women survivors and children.

DSD VEP and training

The national Department of Social Development notes that capacity building is a major priority that requires greater attention. As such, appropriate facilitators have conducted trauma counselling training at various government departments and civil society organisations. Nationally, this training has benefited more than 1700 officials. According to the national DSD, the department also trained 270 social workers in two important programmes aimed at improving support for victims and including females in preventing gender violence.

Firstly, the department trained social workers on a strategy aimed at guiding service providers on 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 survivors would like, amongst other things, more staff, infrastructure development and better staff training on GBV. Secondly, the department trained social workers to implement a strategy on the inclusion and engagement of boys and men in preventing gender-based violence. The inclusion of boys and men in preventing gender violence is crucial because this 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 Euros to assist the Victim Empowerment Programme in the national and provincial departments of Social Development. The commitment is intended to assist in the management, coordination and leadership of the VEP to effectively improve services to victims of crime, especially women and

children. As such, financial resources have been made available and should be utilised more effectively by government to increase accessibility to services in a more equitable manner countrywide.

Engaging traditional leaders

Traditional Leaders in rural communities have a role to preside over customary law courts, assist members of the community in their dealings with the state, counsel governments on traditional affairs and convene meetings to consult with communities on needs and priorities. Traditional leaders wield influence and command much respect within their communities. Traditional leaders as custodians of culture occupy a strong position to work with their communities to address the harmful cultural practices that trigger and perpetuate GBV. In South Africa they preside over customary law courts and reach communities through *imbizos/lekgotlas*, or community dialogues. South Africa's National House of Traditional Leaders has members in all the nine provinces. It is the officially recognised organisation of traditional leaders in the country.[70]

Stakeholders inaugurated the National House of Traditional Leaders on 18 April 1997, originally calling it the National Council of Traditional Leaders (NCTL). But the name changed in 1998 to the National House of Traditional Leaders (NHTL). In his inaugural address to the NHTL, former South African President Nelson Mandela said: "When the new constitution was drafted, there were concerns that it did not define in sufficient detail the status and role of Traditional Leaders and that it did not, unlike the interim constitution, oblige government to set up this council."

The NHTL is an organisation that stands for transformation and equality amongst everyone. It is important to conduct ongoing capacity building with traditional leaders so they can deal with gender-based violence cases on merit and not based on their personal values and attitude. Once confident and skilled, traditional leaders may be able to cascade this knowledge to their communities. Each province, with the exception of the Western Cape, has a Provincial House of Traditional Leaders with a clear, province-specific vision and mission that promotes gender sensitive autonomy, transparency and institutions. NHTL unifies the Traditional Leadership and guides it on protecting diverse cultural practices.

President Jacob Zuma (right) meets with some of South Africa's traditional leaders. *Photo courtesy Google Images*

[70] http://www.popcouncil.org/projects/301_TradLeadSGBVSouthAf.asp

Case study: - Population Council tackles GBV with traditional leaders

Background

The Population Council, in partnership with the Ubuntu Institute, embarked on a programme to engage traditional leaders in three South African provinces (North West, KwaZulu-Natal and Limpopo) to address sexual and gender-based violence (SGBV) in rural communities. The programme's overarching goals included strengthening linkages between the Population Council and traditional communities, generating and sharing strategic information on SGBV, strengthening prevention and response to child sexual assault, engaging new partners to address prevention of and access to SGBV services, and expanding access to comprehensive post-rape services by working with traditional leadership structures.

Objectives

The programme aimed to:

- Explore understanding and perceptions of sexual- and gender-based violence amongst traditional leaders;
- Drive social mobilisation campaigns to address community cultural norms, values and social practices pertaining to SGBV;
- Identify socio-cultural issues that influence a broader understanding of the law that governs gender-based violence and its intersection with customary law; and
- Develop capacity among traditional leaders on sexual and gender-based violence to increase their under-standing and knowledge.

Methods

Population Council, in collaboration with the National Department of Health, conducted three province-specific focus group discussions with 35 traditional leaders - 15 from KwaZulu-Natal, 10 from North West and 10 from Limpopo.

The team identified traditional leaders through local traditional leader organisations in each province such as the House of Traditional Leaders and Congress of Traditional Leaders in South Africa (CONTRALESA). It carried out focus group discussions to gather information from traditional leaders about their perceptions of, and attitudes toward, sexual violence and to establish what roles they believe they can play in fighting SGBV in their communities. The focus groups also aimed to establish what structural issues exist that support or fight against gender-based violence.

Outcomes of focus group discussions

The focus groups confirmed the patriarchal nature of traditional leadership. The majority of traditional leaders are men and the group frequently overruled contributions made by female traditional leaders. The leaders used patriarchy to justify gender-based violence and hold women responsible for it. They gave little acknowledgment of the role played by men in the country's scourge of gender-based violence. Leaders cited women's clothing, including short skirts, as well as refusing to have sex with their partner as reasons that push men to abuse their partners.

Capacity building

Population Council provided technical assistance for three, two-day capacity-building sessions conducted with 126 traditional leaders from KwaZulu-Natal, North West and Limpopo. The sessions aimed to help traditional leaders reinforce their traditional role within their communities, equip them with the knowledge and skills to advise their communities correctly, and to deal with social problems where possible, thus relieving the burden on the justice system.

Feedback on current mechanisms of dealing with GBV

Currently, caregivers take survivors of GBV between three and 15 years old to the traditional court, which is usually made up of a council of traditional leaders or chiefs. These councils that adjudicate on such cases can be found in most traditional authorities. Perpetrators pay a penalty of three to four cows depending on the severity of the case. More complicated cases can often be referred to the higher court systems, for example where evidence is either not conclusive or where there is no evidence other than an allegation or reporting of a case. Traditional court councils typically use a retributive justice system. The focus of the fine is on the family, rather than the individual. Traditional leaders said they had more success dealing with cases where the entire family is involved and where the family can hold an individual accountable as opposed to a punitive system that punishes the individual, who may repeat the offense and has no family to hold him accountable.

Recommendations

The key recommendations from the Population Council's programme note that:

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

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

Conclusion

As highlighted previously, no one factor alone "causes" violence. Instead, a number of factors combine to raise the likelihood that a particular man in a particular setting may act violently toward a woman. As such, for a prevention strategy to be successful it has to touch on all the different facets of life and must be directed across all clusters of society, government departments and civil society. Political will is also critical in preventing GBV, but only if it is accompanied by action and resources. Campaigns also play a part in raising awareness, especially if the targeted population is part of the process.

However, this chapter illustrated that while women in KZN remain the target population for such campaigns, they are relatively unaware of campaigns created for their benefit. The spin off to this is that they fail to be as engaged as their male counterparts.

Women need to be encouraged to participate in these campaigns and strive to own them. Community mobilisation is one of the ways KZN communities have been engaging with the issues and working on campaigns that combat GBV. Community mobilisation ensures local ownership of any GBV interventions.

One of the major drivers of GBV is embedded traditional norms and attitudes about masculinity and femininity. For this reason it is imperative to engage men in efforts to deconstruct gendered ideas of masculinity. Several CSOs have taken up this approach and case studies in this chapter illustrated that it seems to be working quite well. As such it is recommended that other organisations take up this approach, especially in rural areas where some detrimental cultural practices remain common. Education has also been shown to play a part in the prevention of GBV. It also remains critical to education service providers and other personnel who deal with victims of violence.

Based on the case studies presented here, the most effective prevention strategies incorporate both proactive and responsive strategies. There is a need to invest more in primary interventions that seek to prevent GBV before it occurs. At the same time, secondary and tertiary interventions should not be sidelined as these also play a crucial role in preventing recurring acts of perpetration of GBV.

CHAPTER 9
INTEGRATED APPROACHES

Everyone has a right to safety and security. South African activists and survivors prepare to Take Back the Night during the 2009 16 Days of Activism. *Photo by Gender Links*

Key facts

- Since the official launch of the 365 Days NAP, proper implementation of the plan is still non-existent.
- Deputy President Kgalema Motlanthe launched the National Council against GBV on 10 December 2012 in Rustenburg. It has 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 has adopted an integrated and coordinated holistic approach in the fight against crime.
- The Cluster established the JCPS Domestic Violence Task Team to draft, implement and monitor the integrated Domestic Violence Strategy. The Task Team is chaired by the Department of Justice and Constitutional Development.
- The Integrated Victim Empowerment Policy creates a framework to guide and inform the provision of integrated and multi-disciplinary services to address the needs of victims of violent crime.
- The VEP has encountered various challenges since inception, some of which include the lack of monitoring and evaluation mechanisms and inadequate facilities for victims of crime. A glaring gap is the inadequacy of shelters to accommodate victims in the rural areas.
- In KZN, the provincial Department of Community Safety and Liaison has undertaken a number of initiatives aimed at empowering victims of crime, including a council on crime.

(My name is Thembalihle). "I grew up living with my parents and brother in a poor home. Our father used to drink a lot of alcohol and we had very little food to eat at home. After drinking he would beat my mom and chase us away. We would sleep at our neighbours' place or at the shelter. My dad would come to fetch us and then he would beat us and my mother even more. Although my dad was always abusive to my mom, she stayed because of the family.

When I was 15 years old my mother became very sick and then she passed away. My brother left home and stayed with my uncle and I was left with my dad. I lived with my father who used to leave me alone with no food at home and he would go to his girlfriend's home. If I asked for food he would swear at me. Life at home became unbearable so I went to live with my aunty. At my aunt's place my cousin Thabani Xaba used to drink and swear at me. He did things to me that made me feel like he could rape me. He would come to my room as he pleased and pretended to look for something.

When I was 21 years old I met Temba and we started dating. I then fell pregnant and my aunt chased me out of her house. I stayed with my friends and their parents complained that I would be bad influence. My boyfriend invited me to stay with him and his mother even though he also came from a poor home, but he managed. We lived together, then the mother of my boyfriend got sick and she passed away. After she died, my boyfriend and I lived together for a while before he also got sick and passed away when our baby was three months old.

I went back to my aunt's house and the ill-treatment was worse this time. There was a lady who helped me get a job. I sent my child to a crèche. My aunt and cousin continued to be abusive. One day my aunt told me to leave her house with my child. She swore at us saying we were a burden.

Another lady referred me to Lifeline to see social workers. I went to Lifeline and told them my whole story. I was also feeling very sick during that time. I got counselling and they referred me to the Haven Shelter and I lived there with my daughter. In 2010 I felt sicker and went to hospital and the child continued to be at school at the Haven shelter.

When I returned from hospital the house mothers at the shelter took care of me until I got better. Once I was better they asked me to help them at the shelter and to gain a little bit of money to help my daughter. They were impressed by my good behaviour and hired me to become a house mother at the shelter. Even now I am still working at the shelter. I went to study for a home-based care course in 2011. My life became better; I also changed and I now feel better about my life. Even though there are problems, I know that God is with me. I want to finish my schooling and get education."

Thembalihle had a tough childhood and grew up in an abusive family. She is faced with no option other than to live with abusive relatives. However, she is relieved when she gets help from Lifeline. She is even referred to a shelter and thus moves on with her life. This story serves to show that no one sector or institution can tackle gender-based violence alone. As presented in Thembalihle's story, Lifeline provided the psychosocial support while the Haven provided shelter to the woman and her baby. Thembalihle manages to break free and move on with her life as well as advance her career.

This chapter presents integrated approaches that have been rolled out in South Africa in an effort to respond to GBV. The South African Government's National Development Plan Vision for 2030 places emphasis on 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."[71]

[71] http://countryoffice.unfpa.org/southafrica/drive/FinalTORNSPonGBV09July2013.pdf

GBV is such a complex problem that its solution requires strategic and multisectoral coordinated policies and actions, with the participation of both the state and civil society. In this context, the health, regulatory (judicial/legal/law enforcement), education, and non-governmental sectors become fundamentally important. Each of these sectors has a critical role to play in detecting, recording, addressing, and preventing domestic violence. 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). Delegates aimed to devise strategically coordinated 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 specified the 16 Days of Activism is not sufficient to address GBV and noted that a more comprehensive and sustained approach is necessary, including prevention, support and response. The 2007 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).[72] It expects all the South African government departments and civil society organisations to use the National Action Plan as the basis to develop their own strategic and operational plans to ensure unity of purpose and cohesion of efforts to achieve maximum impact in the process of eradicating this scourge.[73]

Vision: A South Africa free from gender-based violence where women, men, girls and boys can realise their full potential.
Mission: To devise a comprehensive and concerted plan for ending gender violence with measurable targets and indicators to which South Africans from all walks of life, in all spheres of government and at all levels of society can contribute.
Goals:

1. To mount a sustained prevention and awareness campaign that extends the Sixteen Days of Activism into a year-long campaign; involves women and men across the country; and has a measurable impact on attitudes and behaviour.
2. To ensure that all relevant legislation is passed, budgeted for, thoroughly canvassed and implemented.
3. To reduce cases of rape by seven to ten percent per annum in line with the SAPS target.
4. To ensure that South African Police Service (SAPS) crime statistics provide particulars on domestic violence and that there is significant reduction of domestic violence each year.
5. To increase conviction rates by 10 percent per annum, including through the rollout of more Sexual Offences Courts.
6. To ensure comprehensive treatment and care for all survivors of gender violence, including the provision of Post Exposure Prophylaxis (PEP) to reduce the chances of HIV infection; treatment for the possibility of STD's and pregnancy as well as counselling.
7. To provide support and empowerment for victims through places of safety, secondary housing and employment opportunities as well as rehabilitation of offenders.
8. To ensure coordination and communication among those involved in the implementation of the plan including through the establishment of appropriate institutional mechanisms.
9. To set targets and indicators that are regularly monitored, evaluated and reported on.
10. To ensure that the plan is widely canvassed and adapted for implementation at all levels: national, provincial and local.

[72] http://www.unicef.org/southafrica/SAF_resources_365daysdeclaration.pdf
[73] http://www.unicef.org/southafrica/SAF_resources_365daysdeclaration.pdf

The box above highlights the mission and goals of the 365 Days National Plan of Action which was developed in 2006. This was meant to be implemented through an integrated multi-sectoral approach. However since it was not properly funded it could not generate the results it was intended to generate.[74]

Evaluation of the 365 NAP

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

Since the official launch of the NAP in 2007, proper implementation of the plan has left much to be desired. The study identified structural and systemic challenges which include poor planning, lack of coordination and accountability, capacity issues and confusion in terms of demarcation of responsibilities among the stakeholders. Although stakeholders costed the plan, legislators did not provide adequate state budgetary allocation for the implementation of the plan, as well as for monitoring and evaluation systems.[75]

Minister of Women, Children and People with Disabilities Lulu Xingwana and Gauteng Premier Nomvula Mokonyane launch a gender project in Pretoria.
Photo by Colleen Lowe Morna

The National Council against GBV

Deputy President Kgalema Motlanthe launched the National Council against GBV on 10 December 2012 in Rustenburg.[76] Motlanthe chairs the council, which is championed by Minister of Women, Children and People with Disabilities Lulu Xingwana.

The council is a national multi-sectoral structure composed of 20 members from government and civil society. Sectors represented in the council include civil society organisations dealing with violence against women and children, religious organisations, traditional leadership, members of the women's movement, academic and research institutions and government across all spheres, and the South African Local Government Association. The establishment of the Council is a direct response to the issues raised at CEDAW following the country report in 2011.

The governance structure of the council is headed by the plenary, the highest decision making body of the National Council, chaired by the deputy president. The secretariat, whose role is to execute and coordinate the work of the council, comes after the plenary. The DWCPD then follows as the lead department in spearheading the fight against GBV.

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

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

[74] http://countryoffice.unfpa.org/southafrica/drive/FinalTORNSPonGBV09July2013.pdf
[75] CGE Report to the Portfolio on Women Children and People with Disability , 2013.
[76] http://www.services.gov.za/services/content/news/GenderBasedViolence/en_ZA

The work of the Council pertaining to the 365 Days NAP is anchored on six pillars:

1. Communication and coordination pillar

The development of the National Communication Strategy is underway. This is aimed at changing behaviours. The council will hold consultations with relevant stakeholders to strengthen provincial, national and international partnerships and alliances. It will also facilitate and coordinate all stakeholders for partnership around national events, interventions and mobilisation for indicated action. In addition, the council will strengthen and facilitate interdepartmental collaborations. It has also planned to hold consultations and mobilise resources. Apart from that 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

Some of the activities lined up under this pillar include conducting education and awareness programmes and organising inter-generational dialogues. The council will also organise and coordinate inter-sectoral seminars, workshops and conferences as well as popularise the victim support programmes, policies and legislation. The prevention strategy will also include strengthening campaigns against alcohol, substance abuse, Satanism, muti killings and witch killings.

3. Research and information pillar

This pillar is as important as the previous two. It will involve auditing research conducted on GBV as well as mapping of hot spot 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 up-scaling 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. Furthermore, it will strengthen accountability of public and private sector entities through effective monitoring. Another responsibility pertaining to support is to address the discrepancies between rural and urban areas.

5. Response pillar

In regards to response to GBV the council is mandated to monitor and evaluate the response of the public and private institutions and to facilitate the roll-out of green/white doors to other provinces.[77] On top of that, the council will also strengthen the multi-sectoral rapid response programme to facilitate immediate access to services.

6. Monitoring and evaluation and policy pillar

It is the council's role to facilitate the popularisation of legislation dealing with violence against women and children. It is also to facilitate the review of legislation and policies dealing with GBV, in particular the Domestic Violence Act 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

[77] The white or green doors were houses that were being offered by the community to victims of GBV at any time of the day as a refuge until they got assistance from the relevant structures (DSD).

Stakeholders created the council in 2011 to help alleviate gender-based violence. Cabinet had approved the recommendation to establish the National Council on 5 December 2011 and subsequently inaugurated it on 10 December 2012. To date, no tangible achievement can be attributed to the council. Like many other comprehensive strategies that have been adopted and rolled out the government, it has not earmarked sufficient funds to ensure successful implementation of the strategy.

National Justice Crime Prevention and Security (JCPS)

The Justice Crime Prevention and Security (JCPS) Cluster has been mandated to achieve Outcome 3 of the Priorities of Government, namely that all people within South Africa feel and are safe. The cluster is responsible for implementing various governance structures that seek to address the issue of safety, including GBV. The structures include[78]:

Table 9.1: Structures in place to ensure public safety

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

The Cluster has adopted an integrated and coordinated, holistic approach in the fight against crime. It seeks to continue to improve prevention, detection, investigation and prosecution through integrated policies and frameworks and increased capacity.

Various protocols have received attention around implementation of the Seven Point Plan to ensure the effectiveness of the Criminal Justice System (CJS). This includes court screening protocol and a legal aid court protocol to improve coordination of work between the National Prosecuting Authority and the legal aid representatives. Court Screening has been developed to ensure case readiness and improve case scheduling.

Stakeholders finalised the National Policy Framework (NPF) regarding Diversions in May 2010. The Policy Framework supports the Child Justice Act that lawmakers implemented in April 2010. In regards to the SOA 2007, stakeholders developed a draft Sexual Offences NPF to improve and coordinate the criminal justice system's responses to sexual offending, improve how the judiciary deals with cases at court level and regulate the approach used when dealing with sexual offences and related matters. This means dealing with these matters in a coordinated and sensitive manner with an emphasis on a multi-disciplinary approach.

The JCPS cluster also focuses on creating awareness - especially in rural communities - about issues that relate to crimes committed under the guise of customary practices. The cluster makes it clear that any criminal act of kidnapping and rape inflicted on young and defenceless girls and disguised as the cultural practice of *ukuthwala* will not be tolerated.[79] As such it will continue to work together with traditional leadership to tackle this serious issue. The cluster also prioritises crimes against women and children and provides support through Thuthuzela Care Centres.[80]

[78] http://www.pmg.org.za/print/report/20120215-department-justice-constitutional-development-implementation-domestic
[79] 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.
[80] Department of Justice and Constitutional Development 20 Feb 2011

JCPS Domestic Violence Task Team

After having noted the lack of a coordinated strategy between JCPS cluster departments in the implementation and monitoring of the DVA, the cluster established the JCPS Domestic Violence Task Team. It tasked the team with drafting, implementing and monitoring the integrated Domestic Violence Strategy. The JCPS mandated the DoJCD to chair this JCPS Domestic Violence Task Team. The Team consists of the DoJCD, NPA, Legal Aid SA, SAPS, social develop-ment, health and the judiciary. The departments of women, children and people with disabilities; COGTA (NHTL), transport, and housing also play ancillary roles.

The Integrated Victim Empowerment Policy

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

More specifically, the IVEP aims to:

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

Intervention strategies

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

The National Victim Empowerment Programme (VEP)

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

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

To ensure integrated and coordinated services between government departments (at various levels) and civil society, the NVEP is comprised of various structures. These include an integrated inter-sectoral Victim Empowerment Management Team (VEMT) consisting of representatives from the national departments including Department of Social Development (DSD), correctional services, justice and constitutional development (DOJ&CD), South African Police Service (SAPS), the National Prosecution Authority (NPA) and the department of health (DOH). The DSD is the lead department on the programme and coordinates the programme within the criminal justice system. Different departments play different roles in the provision of services to victims of crime and violence. The services vary from registering and investigating a case by a victim, to offering medico-legal services by health professionals and ultimately prosecuting the case through the courts.

The VEMT is responsible for determining the strategic direction with regard to the management of the NVEP, and ensuring that respective departments address all issues pertaining to victims.

The following table shows the different roles of the departments within the VEMT.

Table 9.2: 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.

The partnership between various government departments and civil society on 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.

Figure 9.1: South Africa DSD framework: victim-centred approach

Figure 9.1 demonstrates how the different departments work in unison within a victim-centred approach. Such strategies should be coordinated within the department and between relevant departments to ensure a holistic approach to service delivery with no duplication of services and service delivery, thus ensuring optimal use of the limited resources (Integrated Victim Empowerment Policy Draft 2007).

Evaluation of the VEP programme by UNDOC

The VEP has encountered various challenges since inception, some of which include the lack of monitoring and evaluation mechanisms and inadequate facilities for victims of crime and the broad geographic spread of such facilities. A glaring gap is the inadequacy of shelters to accommodate victims in the rural areas.

Victims do not always receive the type of services they deserve and high staff turnover hampers effectiveness and progress. The programme is short-staffed and the counsellors and social workers currently available do not tally with the number of victims.

Lack of a strong communication and marketing strategy has also impeded the effective administration of

the programme. Although the programme has managed to strengthen coordination between government departments and CSOs, several other relevant departments have not been fully involved. For instance the department of education is not actively participating in VEP activities. However, over the years government has made efforts to strengthen the programmes (UNODC-South Africa's Victim Empowerment Programme, final independent evaluation).

Coordination structures at provincial level

The KwaZulu-Natal Council Against Crime (KZNCAC)

The KwaZulu-Natal cabinet approved the formation of the KwaZulu-Natal Council Against Crime (KZNCAC) as a platform for the coordination of all province-wide initiatives against crime. Officials launched the KZNCAC in September 2013. It comprises religious leaders, youth formations, provincial community, police board, House of Traditional Leaders, business leaders, organised labour, KZN Community Crime Prevention Association, South African Military Veterans Association and the transport sector.

The terms of reference of the council commit it to:

1. Provide strategic advice and guidance on, and assist in the development of, safety and crime prevention strategies for the province of KwaZulu-Natal;
2. Guide the implementation of safety and crime prevention strategies for the province of KwaZulu-Natal;
3. Monitor and review progress of safety and crime prevention strategies of the province of KwaZulu-Natal;
4. Facilitate, guide and contribute to safety and crime prevention research and project activities;
5. Facilitate support to key government and non-government organisations in the pursuance of their safety and crime prevention strategies;
6. Within the context of the safety and crime prevention strategies of the province of KwaZulu-Natal to identify, investigate and report on safety and crime prevention challenges and opportunities;
7. Initiate and facilitate such working groups as may be necessary to assist in the development, encouragement and promotion of safety and crime prevention programmes and activities;
8. Facilitate, encourage and promote broad societal education programmes for people of all ages in KwaZulu-Natal on the prevention of crime in the community; and
9. Acknowledge the action and activities of individuals and groups actively working towards developing and implementing appropriate strategies for safety and crime prevention.

Decentralisation: district community safety coordination

At the district level, the role of the KZNCAC will be fulfilled by district Community Safety Forums (CSFs) - structures founded on the principles of the National Crime Prevention Strategy. CSFs comprise multi-agency structures established at a district level to ensure the coordination of community safety efforts by government and civil society to address the specific needs of each district. The composition and terms of reference of the KZNCAC will be replicated in district CSFs. This will ensure that they perform the role of coordination centres of district community safety networks and the function of driving the production and implementation of the safety components of Integrated Development Plans (IDPs).

District CSFs will meet once per quarter and will submit reports on their activities to the KZNCAC twice per annum. The KZNCAC will meet twice per annum.

Adapted from launch speech by KZNDCSL MEC

Case study: Durban Local Victim Empowerment Forum KZN

The provincial stakeholders that form part of VEP forum include the NPA, DoJCD, the SAPS, Welfare Probation, Kerr House, Childline KZN, Sibusisiwe Child Welfare, Save the Children, Durban Lesbian and Gay Community Health Centre, the department of health, Department Of Education. In 2012, the forum held a meeting to assess progress in the implementation of VEP within the different departments. At this meeting the departments highlighted some of the challenges they meet as they respond to GBV. The challenges presented by each department include:

Department of Justice and Constitutional Development

Key issues raised by the DoJCD include the lack of coordination between the department and the SAPS. The department said police officers do not provide adequate assistance with the completion of the application forms, leaving gaps in information in case files and dockets. In some instances police do not complete or stamp the form. The incomplete forms or forms with insufficient information on them lead to delays in the court processes. It can also mean the matter is stalled until all relevant questions have been addressed. The department also said police officers have turned away applicants of domestic violence protection order when they try to lay assault charges. The department identified Brighton Beach Police Station and Cato Manor Police Station as the worst offenders. Further, the department said when police deal with minors they often fail to inform parents of the victim about the process, and progress, of cases.

The NPA emphasised that the SAPS should inform the victim and family of the reasons and conditions of bail when bail is granted. Other issues highlighted include lack of follow-up with the victims and the problem of witnesses arriving at court unprepared and without guidance.

KZN Department of Health (KDOH)

The KDOH reported a lack of coordination between the different stakeholders, such as the health and police officials, as well as the surgeons and prosecutors. It said this challenge is most common at Adding-ton Hospital and Thuthuzela Care Centres at three hospitals, namely Mahatma Gandhi Memorial Hospital, Prince Mshiyeni Hospital and RK Khan Hospital.

Another challenge that hinders the KDOH's response is the under-staffed health sector, particularly the problem of not enough trained health care workers. This challenge has consequently led to lack of trained nurses to deal with sexual offenses as well as dedicated staff in crisis centres. This result is that victims must wait many hours before they can be attended by doctors and nurses. In addition, the department noted a lack of interaction between the KDOH and forensic laboratories. Usually the doctors take specimens and use the kits but they do not link up with the labs.

Similarly, the courts have difficulty assessing results. In general the department observed that there is a significant lack of perception of rape as "an emergency" among health personnel. As such, it recommended the need to place a greater focus on minimising secondary trauma by providing comprehensive management for the victim.

Probono.org

Probono is one CSO that is actively involved in the forum. It says it is impeded by court officials who do not provide enough assistance to applicants, especially in circumstances where a domestic violence application is opposed. It has also noted that its work is impeded because of long delays in getting family advocate reports.

It is evident that one of the most cited challenges around implementation involves lack of coordination between different sectors working in gender-based violence. This defeats the purpose of the VEP, which is meant to provide a multi-sectoral approach in addressing DV. With this in mind there is a need for more comprehensive monitoring and evaluation mechanisms to ensure that each department is playing its part in assisting the victims. It is also important for all stakeholders to provide more clarity regarding their roles, responsibilities and needs. In addition, these examples highlight the need for greater transparency throughout this process in order to ensure victims of violence get the best care and assistance possible.

Conclusion

It has been widely established that no single sector, government ministry, department or civil society organisation can by itself holistically address the GBV epidemic. As such, South Africa, along with other nations, has adopted multi-sectoral approaches that include various stakeholders who can come together with one goal of addressing GBV. While the South African government can be applauded for taking meaningful strides to create comprehensive strategies that promise to take prevention and response efforts to new levels, they have yet to provide adequate resources needed to implement them. Actual implementation perpetually lags far behind as GBV continues to take its toll on South Africa's communities. A toll that, in the end, will cost the government much more money than the amount of money needed to turn the country's GBV strategies into solid action.

Despite this lack of funding, this chapter has shown the various ways South Africa and KwaZulu-Natal have established task teams, plans and frameworks in an effort to deal with GBV. However, although these developments qualify as relevant steps towards elimination of this scourge, they are not going to help much unless they are further fortified by the much needed resources. Stakehoders formed the National GBV Council to provide guidance in the coordination of different groups that work with the victims of violence. One year later it appears the council is still trying to find its feet. A speech given by a representative of the Department of Women, Children and People with Disabilities in June 2013 said the council is still grappling with issues pertaining to its governance structure and budget allocation.

The VEP is another widely accepted example of best practice that has been met with various challenges - the most striking is an ongoing lack of coordination between the various sectors. This chapter also highlighted the problem of a troubling lack of trained staff to assist victims of gender-based violence. From these few examples it is evident that there is a need for serious political will, backed up by adequate financial commitment, in the fight against GBV. Equally important is the need to increase and fortify monitoring and evaluation at both national and departmental levels. For integrated approaches to be effective they need to offer clarity and accountability in the execution of all the roles played by each different sector.

CHAPTER 10

CONCLUSIONS AND RECOMMENDATIONS

As 2015 approaches it's more important than ever to get the message out: Real men don't abuse women and children. *Photo by Gender Links*

Extent

This report has shown that like many other parts of South Africa, KZN exhibits high prevalence rates of violence against women. On the other hand, disclosure rates to police and medical personnel remain relatively low. It is necessary to implement greater measures to get rid of the stigma associated with VAW so that victims can openly report abusive acts without fear or shame. Personnel working closely with the victims also need to be trained to provide the proper response to the victims. This study found that intimate partner violence (IPV) is the most prevalent form of VAW, with 31% of women having been subjected to it. The findings in this study point to a great need to challenge some harmful cultural practices condone violence against women in domestic relationships. Women in the study also underreport the various forms of IPV. Other forms of GBV that must urgently be addressed include abuse during pregnancy and sexual harassment.

Drivers

Among the demographic factors, researchers found level of education and age to be significantly associated with lifetime IPV perpetration. Level of education is also associated with non-partner rape perpetration - researchers found that men with a high school committed less rape than men who did not complete high school. This implies the need to promote formal education among men. It is also important to educate men about gender issues to reduce attitudes of male supremacy which promote VAW. Despite these stark findings, the majority of men and women in this study agreed to the notion of gender equality. However, this has not translated into equality, which means there remains an urgent need to address harmful gender attitudes and stereotypes. This study found that such attitudes continue to condone abuse in the domestic domain and allow men to feel entitled.

This study also illustrated that alcohol is a key driver of violence. This connection needs to be further studied in order to enable comprehensive interventions to curb IPV perpetration. There is a need to set up interventions to regulate and discourage excess alcohol consumption in the country. These may include enforcing and increasing alcohol tax and regulation of drinking points and amount of consumption per person.

This study found that a greater proportion of men who experienced child abuse reported IPV perpetration and non-partner rape than men who had not been abused in childhood. As such it is critical to prevent various forms of child abuse. Parents need to be exposed to interventions that educate them to bring up their children in non-abusive environments. In addition, it is important to provide adequate psychological support for those children who would have undergone child abuse in order to enable healing.

Political speeches analysed in this study indicate that government is still far from sufficiently understanding and addressing GBV in this country. It is essential to continue and increase work that informs and educates key government departments and legislators about the impact, and high cost, of gender-based violence. In addition, it is important to also further educate regular South African citizens about the scourge of GBV so they can put pressure on the government to do something about it.

Effects

This study showed that IPV operates through various pathways and ends in either death or disability and it identified several effects of violence. It established that the health sector must play a greater role in responding to intimate partner violence and sexual violence against women. It is important to promote further screening of injured persons to make early detections needed to provide proper referrals for the victims. Similar procedures must be carried out for those women who access reproductive health services.

Apart from physical effects, this report looked at the psychological and economic effects of GBV. The report established that KZN has high levels of mental health problems associated with violence against women, yet at the same time psychiatric and mental health services do not have adequate funding, infrastructure, development and staffing (Burns,

2010). Overall, this research shows that violence against women is not a small problem that only occurs in some pockets of society - it is a global public health problem of epidemic proportions that requires urgent action in order to avoid more preventable deaths and disabilities.

Support

This study provided further proof that KZN and the entire country of South Africa do not have enough shelters to provide for the high number of victims who need them. Those few shelters that exist are mainly run by NGOs that continually face funding challenges which threaten the sustainability of operations. Other challenges faced by shelters include recurrent survivors who fail to leave their situations and hence return to shelters. The shelters and other institutions rendering support to victims of violence need to be provided with sustainable financial support. It is also important to increase efforts to provide second and third stage houses for recurring victims. The province also needs to strengthen its referral system and replicate best practices that have yielded positive results.

Prevention

Researchers established that political will plays a major role in preventing VAW only if it is accompanied by action and resources. Thus, there is a need for ongoing and high level engagement with the government and policy makers in order to increase the political commitment to eliminate violence against women. This report revealed that while women remain the target audience for most GBV campaigns, they remain relatively unaware and fail to participate in these campaigns. Meanwhile, their male counterparts are better informed and more likely to take part. Women need to be encouraged to increase their participation in these campaigns and strive to own them.

This study showed that community mobilisation is an effective method of engaging the community in efforts to prevent violence against women. As such it is recommended that other organisations take up this approach, especially in rural areas where some detrimental cultural practices remain common. Education also plays a part, which is why formal education is important and further education is needed for those who deal with victims of violence. This report established a need to invest more in primary interventions that seek to prevent VAW before it even occurs. This speaks to investing in the younger generations and socialising them about the importance of gender equality. At the same time, secondary and tertiary interventions should not be sidelined as these also play a part in preventing recurring acts of perpetration of victimisation of VAW.

Integrated approaches

South Africa has established task teams, plans and frameworks in its effort to deal with violence against women. However, actual implementation is still lagging behind while violence continues to take a toll on communities. There is a need for serious political will and adequate financial commitment in the fight against GBV. Equally important is the need to increase and fortify monitoring and evaluation at both national and departmental levels. For integrated approaches to be effective there is also a need for clarity and accountability in the roles played by the different sectors.

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GBV AND THE SADC PROTOCOL ON GENDER AND DEVELOPMENT

Response and support

The SADC Protocol provides that by 2015 state parties shall:

- Enact and enforce legislation prohibiting all forms of gender-based violence;
- Ensure that laws on gender-based violence provide for the comprehensive testing, treatment and care of survivors of sexual assault;
- Review and reform their criminal laws and procedures applicable to cases of sexual offences and gender-based violence;
- Enact and adopt specific legislative provisions to prevent human trafficking and provide holistic services to the victims, with the aim of re-integrating them into society;
- Enact legislative provisions, and adopt and implement policies, strategies and programmes which define and prohibit sexual harassment in all spheres, and provide deterrent sanctions for perpetrators of sexual harassment.

Prevention

- The Protocol provides for measures, including legislation, to discourage traditional and cultural practices that exacerbate gender-based violence and to mount public campaigns against these.

Integrated approaches

- The SADC Protocol on Gender and Development calls on states to adopt integrated approaches, including institutional cross sector structures.

The ultimate goal….

- To reduce current levels of gender-based violence by 2015.

The GBV Indicators Baseline Study of KwaZulu-Natal provides the first comprehensive baseline data on the extent and patterns of violence against women (VAW) in the province. It is commendable that various actions plans to end GBV have been set up in the country. However, there is still too big a disjuncture between the rhetoric of gender equality, and the reality on the ground. I see this research as contributing to CEDAW General Recommendation 19, which calls upon member states to put strategies in place to address GBV and this research report will assist KZN government to tackle these issues from the informed position.

If we accept that GBV is the single most flagrant violation of human rights in South Africa post democracy, we must also accept that there is need to invest government resources in establishing the true extent of this scourge, and what needs to be done to end it, once and for all. We call on the National GBV Council to take up this initiative, and escalate it to national level. We call upon family structures, KZN traditional leaders and Faith Based Organisations and employers to use the report to uproot the scourge of GBV. We call upon all men to take the centre stage to reverse the issues raised by the study. The KZN Men's Forum should take a lead and work with all men to deal with GBV.

As the Commission, we believe strongly that these findings will not only lead to informative discussions with the relevant stakeholders in KwaZulu-Natal, and broader gender sector, but they will inform policy discussions, programme implementation and way forward on the future of GBV approach.

I take this opportunity to thank all partners who took part and contributed to this research, and to the sponsors - UKAID and FOKUS. Together we can end gender violence and take South Africa forward. ***Yes we can, and yes we must!***

Mfanozelwe Shozi
Chairperson of Commission for Gender Equality