Masiphephe Network

Collaboration in Gender-Based Violence Response, Access to Justice and Prevention

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USAID FROM THE AMERICAN PEOPLE

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This report is dedicated to our late colleague

Dr Aisling Health

who was at the helm of this research project from 2018 until she passed away in June 2019.

May our sister's soul continue to rest in peace.

Masiphephe Network

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LIST OF ACRONYMS AND ABBREVIATIONS

ADAPT	Agisanang Domestic Abuse Prevention and Training
AGBH	Assault Grievous Bodily Harm
AIDS	Acquired Immunodeficiency Syndrome
ANC	African National Congress
BPFA	Beijing Platform for Action
CADCA	Community Anti-Drug Coalitions of America
CBO	Community Based Organisation
CCI	Centre for Communication Impact
CCGs	Community Care Givers
CCN	Community Collaborative Network
CJ	Criminal Justice
CJA	Child Justice Act
CJS	Criminal Justice System
CoGTA	Cooperative Governance and Traditional Affairs
CPF	Community Policing Forum
CPW	Community Programme Worker
CRU	Community Residential Unit
CSC	Client Service Centre
CSVR	Centre for the Study of Violence and Reconciliation
CWH	Community Health Worker
DCS	Department of Correctional Services
DoBE	Department of Basic Education
DoH	Department of Health
DoJ & CJ	Department of Justice and Constitutional Development
DoSL	Department of Safety and Liaison
DR	Doctor

DSD	Department of Social Development
DV	Domestic Violence
DVA	Domestic Violence Act
ECC	Ethembeni Crisis Centre
ECD	Early Childhood Development
FAMSA	Families South Africa
FCS	Family Violence, Child Protection and Sexual Offences
FGD	Focus Group Discussion
FOVOC	Foundation for Victims of Crime
FSL	Forensic Science Laboratory
GBV	Gender-Based Violence
GBVF-NSP	National Strategic Plan on Gender-Based Violence and Femicide
GDF	Gugu Dlamini Foundation
GDP	Gross Domestic Product
GHJRU	Gender, Health and Justice Research Unit
GRIP	Greater Rape Intervention Project
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
ICMS	Integrated Case Management System
ICOP	Improving Case Outcomes for Sexual Offences Cases Project
IDP	Integrated Development Planning
IFP	Inkatha Freedom Party
IO	Investigating Officer
IPV	Intimate Partner Violence
LA	Liquor Act No. 53 of 2003
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex and Asexual
MSSVC	Minimum Standards on Services for Victims of Crime
NACOSA	Networking HIV and AIDS Community of South Africa
NCPS	National Crime Prevention Strategy

NDP	National Development Plan
NPO	Non-profit Organisation
NSP	National Strategic Plan
NVEP	National Victim Empowerment Programme
OSC	One-Stop Centre
OSS	Operation Sukuma Sakhe
PEP	Post Exposure Prophylaxis
PO	Protection Order
POWA	People Opposing Woman Abuse
PSASA	Project Support Association Southern Africa
PTSD	Post-Traumatic Stress Disorder
QLFS	Quarterly Labour Force Survey
SADC	Southern African Development Community
SAMRC	South African Medical Research Council
SANCA	South African National Council on Alcoholism and Drug Dependence
SAPS	South African Police Service
SASSA	South African Social Security Agency
SGJ	Sonke Gender Justice
SHARE	South Africa HIV and AIDS Regional Exchange
SLT	Social Learning Theory
SOAA	South African Sexual Offences and Related Matters Amendment
STATS SA	Statistics South Africa
TCC	Thuthuzela Care Centre
UCT	University of Cape Town
UN	United Nations
UNAIDS	United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
VAC	Violence against Children
VAW	Violence against Women

VAWC	Violence against Women and Children
VC	Victims' Charter
VEP	Victim Empowerment Programme
VFF	Victim Friendly Facility
VOD	Victim Offender Dialogue
WHO	World Health Organization
WITS-RHI	Wits Reproductive Health Institute

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CHAPTER 1

1.1 INTRODUCTION AND BACKGROUND

The Centre for Communication Impact (CCI) is a registered South African non-profit, apolitical organisation that aims to improve the health and well-being of all South Africans, through strategic policy advocacy. CCI leads the implementation of the Strengthening Local Governance to Improve Gender-Based Violence (GBV) Response Project, also known as the "Masiphephe Network" (meaning "Let's Be Safe"). CCI works in partnership with the University of Cape Town's (UCT) Gender, Health and Justice Research Unit (GHJRU), the Masiphephe Network's research and policy advocacy technical lead, as well as with six community partner organisations in Gauteng, KwaZulu-Natal and Mpumalanga Provinces:

- Agisanang Domestic Abuse Prevention and Training (ADAPT) in the City of Johannesburg (Gauteng Province)
- Sonke Gender Justice (Sonke) in the City of Johannesburg (Gauteng Province)
- Ethembeni Crisis Care Centre (ECCC) in eThekwini Metro (KwaZulu-Natal Province)
- Gugu Dlamini Foundation (GDF) in eThekwini Metro (KwaZulu-Natal Province)
- Project Association Southern Africa (PSASA) in the City of Mbombela and Emalahleni local municipality (Mpumalanga Province)

Collaboratively with national, provincial, and mostly local community level government departments, civil society and community organisations, the Masiphephe Network's goal, in selected sites in the three provinces, is:

> "to reduce vulnerability to GBV through improved local governance and service delivery. The strategic objective is to strengthen the capacity of local structures to lead, coordinate, cultivate and sustain multisectoral action; and manage a community response to GBV prevention and mitigation."

Integrated interventions are aligned to achieving the tenets of the White Paper on Safety and Security (Civilian Secretariat for Police 2016), and the GBVF-NSP (RSA 2020d); through achieving four interrelated outputs: (i) Strengthened community governance and accountability; (ii) Increased primary and secondary GBV prevention; (iii) Improved mitigation

of GBV harms (tertiary prevention); and (iv) Improved access to justice for all victims and survivors[1] of GBV; to facilitate the objective of building safer communities in South Africa as set out in the National Development Plan (NDP).

To achieve the goals of this project, an evidence-based approach was adopted through conducting a qualitative study led by a research team from the GHJRU. Findings from this research will serve as a guideline in the evaluation of the project sites' responses to and prevention of GBV. The aim of the search was to explore issues of GBV experienced in three provinces and six communities, namely, Gauteng (Alexandra and Diepkloof); Mpumalanga (Emalahleni and Mbombela); and KwaZulu-Natal (KwaMashu and KwaNdengezi). The study further explored the approaches and programmes utilised by various statutory (government) and non-statutory (civil society) institutions dealing with GBV issues. The research objectives were to identify:

- The roles of local organisations that deal with GBV issues;
- Local GBV response and prevention gaps;
- Local GBV response and prevention strengths;
- Main GBV crimes reported;
- GBV risk factors;
- Challenges relating to access to justice or the criminal justice system (CJS);
- Current victim/survivor referral and follow-up tools;
- Skills required by individuals employed by organisations dealing with GBV issues; and
- Support required by individuals employed by organisations dealing with GBV issues.

1.2 LITERATURE REVIEW

1.2.1 Nature and extent of GBV

While women and children (more especially girls) are disproportionately affected by GBV, it affects anyone, regardless of his or her geographical location, social and economic status,

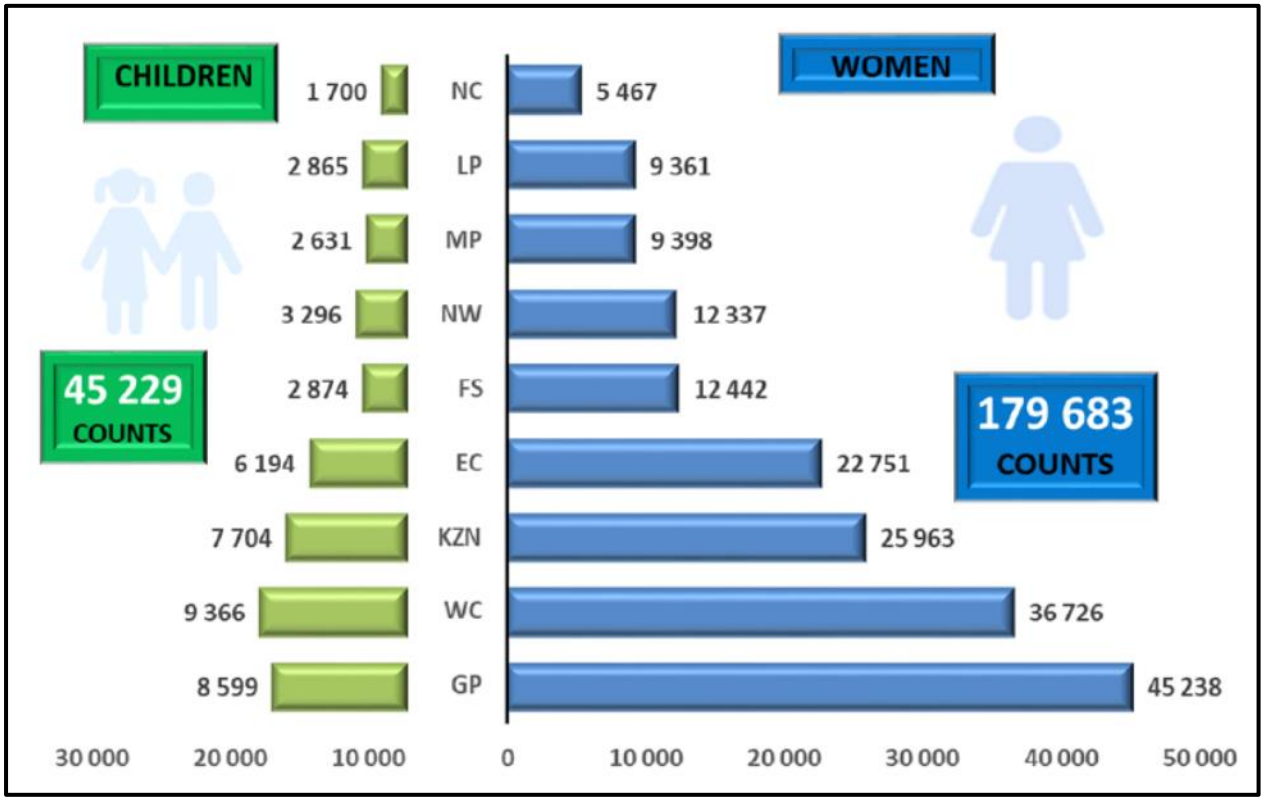
[1] The terms "victims" and "survivors" are used interchangeably throughout the report.

race, religion, culture, or gender identity. A 2012 survey study conducted with 5 621 South Africans in four provinces by Gender Links revealed that 77% of women in Limpopo, 51% in Gauteng, 45% in the Western Cape and 36% in KwaZulu-Natal had been victims of some form of GBV at least once in their lifetime. These include emotional, economic, physical, or sexual abuse. It was also found in the same study that men are, in the majority of GBV cases, the perpetrators with 76% of men in Gauteng, 48% in Limpopo and 41% in KwaZulu-Natal admitting to committing GBV (Gender Links 2012). Research conducted by Abrahams, Jewkes and Laubscher (1999), where 1 306 surveys were conducted in three provinces of South Africa, reported that 27% of women in the Eastern Cape, 28% in Mpumalanga and 19% in the Northern Province (now known as Limpopo) had experienced physical abuse committed either by their current or a previous partner. Further revealed by this study was that 51% of women in the Eastern Cape, 50% in Mpumalanga and 40% in Limpopo experienced emotional and financial abuse in the year prior to the research (Abrahams et al 1999).

As depicted by Figure 1 below, the South African Police Service (SAPS 2019) recorded 179 683 cases of violence against women (VAW) and 45 229 cases of violence against children (VAC) during the 2018/19 reporting period. A comparison between the three provinces where this study was based shows that the highest number of VAW cases reported in 2018/19 can be attributed to Gauteng (n=45 238) followed by KwaZulu-Natal (n=25 963) and Mpumalanga (n=9 398). Together, the three provinces contributed 45% (n=80 599) of the overall number of VAW cases reported in 2018/19 nationwide (SAPS 2019).

Where VAC is concerned, 8 599 of the 2018/19 incidents were reported in Gauteng, 7 704 were recorded in the KwaZulu-Natal Province while 2 865 cases were reported in Mpumalanga. Like VAW incidents, Gauteng reported the highest number of VAC cases. While Gauteng is the smallest province out of the three and in the country by area, it reported the highest number of cases of violence against women and children (VAWC) in 2018/19. The obvious reason attributed to the latter is the fact that Gauteng, specifically Johannesburg, where two of the project communities are situated, is the financial hub of South Africa.

Figure 1: SAPS VAWC 2018/19 cases



Source: SAPS (2019)

Gauteng has the biggest population due to migration of entrepreneurs and job seekers not only from other provinces within the country but also from other countries, especially on the African continent, because of opportunities it offers (Fourie 2016). However, services do not increase in line with the population and thus great demand is placed on available services.

The literature review in this report focuses on sexual offences, physical abuse, which includes common assault and grievous bodily harm (GBH), and murder, as described below.

1.2.1.1 Sexual offences

Based on the crime statistics by the SAPS, most of the sexual offence cases reported during the three-year period from 2016/17 to 2018/19 include **rape**. A total number of 41 583 cases of rape were recorded in 2018/19 (refer to Figure 2 below), which is an increase of 3.9% from the previous reporting year (SAPS 2019). In terms of gender, women experienced more rape

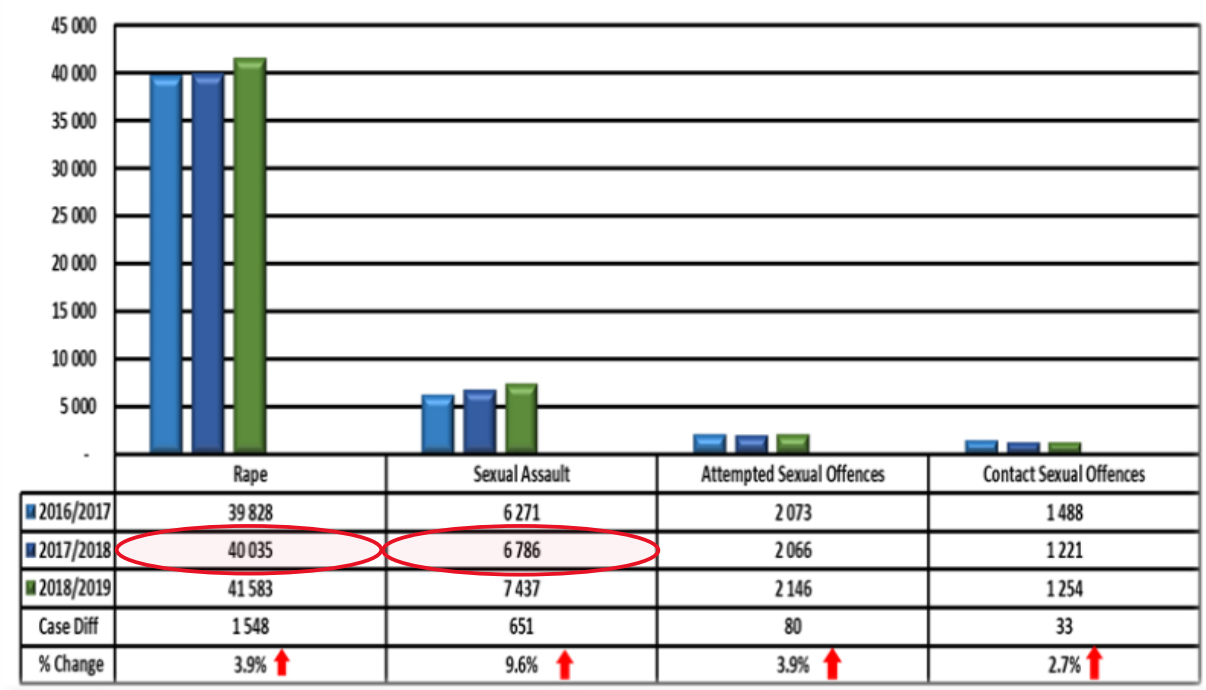
in all the three provinces where the research was conducted accounting for a combined total of 16 720 incidents in 2018/19. In Gauteng, in 89% of the rape cases, the victim was a woman (n=6 340) while men (n=827) were victims in 11% of the rape incidents. In KwaZulu-Natal, women were victims in 90% of the cases (n=5 895) in comparison to 10% of the cases (n=674) reported by men (SAPS 2020). Likewise, of the 2 590 rape incidents recorded in Mpumalanga in 2018/19, women were victims in 2 348 of the cases whereas men were victims in 242 of the incidents. Additionally, in 2018/19, girls were raped more often than boys.

In the Rape Justice in South Africa research conducted by the South African Medical Research Council (SAMRC) (Machisa et al 2017), which studied 3 952 cases reported in 2012 to 170 police stations across South Africa, it was revealed that 46% (n=1 818) of rape cases involved child victims. In approximately 84% (n=1 527/1 818) of rape cases of children, the perpetrators were men known to the children, such as educators, for example (Machisa et al 2017), while 40% of adults were raped by a stranger. Children's vulnerability to violence arises from the fact that they are dependent on adults, parents or caregivers. In 90% of all (n=3 952) cases (children and adults included), perpetrators were male (Machisa et al 2017).

Other vulnerable groups susceptible to rape are the elderly (60 and older) that had an overall total of 1 284 cases recorded by the police in 2018/19 (SAPS 2019) and people with disabilities who made up 4.9% of victims in the 3 952 cases analysed (Machisa et al 2017). It is, however, reported in the same research that rape of children with disabilities is under-reported.

As depicted in the Figure 2 on the next page, **sexual assault** contributed to the second highest number of sexual cases (7 437) recorded by the SAPS in 2018/19. Based on the Optimus Study on Sexual Victimisation of Children in South Africa conducted by Artz, Ward, Burton, Leoschut and Kassanjee (2016), out of a sample of 9 717 young people interviewed, 35.4% (that is, one in three) reported having experienced some form of sexual abuse at some point in their lives. Moreover, 40% of the young people who reported some form of sexual abuse reported experiencing sexual abuse two or more times. Burton (2006) adds that children are twice as likely as adults to experience violence as well as more than one type of crime

Figure 2: Sexual offences (2016/17–2018/19)



	Rape	Sexual Assault	Attempted Sexual Offences	Contact Sexual Offences
2016/2017	39 828	6 271	2 073	1 488
2017/2018	40 035	6 786	2 066	1 221
2018/2019	41 583	7 437	2 146	1 254
Case Diff	1 548	651	80	33
% Change	3.9% ↑	9.6% ↑	3.9% ↑	2.7% ↑

Source: SAPS (2019)

Where provincial statistics are concerned, cases of sexual assault reported in 2018/19 increased in seven (7) provinces except in the Western Cape and Northwest where slight decreases of 0.5% and 3.8% were witnessed respectively (SAPS 2019). As expected, Gauteng reported the highest number (n=10 752) of sexual offence incidents, followed by KwaZulu-Natal (n=9 308) and then Mpumalanga (n=3 470). However, out of the three project provinces, Mpumalanga reported the biggest increase of 8.5% (n=272) when 2018/19 cases were compared to the previous year while Gauteng and KwaZulu-Natal recorded an increase of 6.3% each.

A limitation that should be noted regarding the sexual offences statistics per gender is that incidents are aggregated under the heterosexual cisgender[2] category and thus making it impossible to understand the extent of sexual offences against members of the lesbian, gay,

[2] Cisgender is a term used to refer to people whose gender identity matches their sex assigned at birth.

bisexual, transgender, queer, intersex, and agender (LGBTQIA+) community.

1.2.1.2 Physical violence (common assault and assault GBH)

For contextualisation purposes, common assault "consists of unlawfully and intentionally

- applying force to the person of another; or
- inspiring a belief in another person that force is immediately to be applied to him or her" (SAPS 2020).

GBH is a form of assault intended to cause serious bodily injury (SAPS 2020).

Based on the explanations above, common assault is thus deemed the lowest category of assault that carries a lighter sentence, such as a fine, for example, while assault GBH is deemed the highest category of assault and carries a heavier sentence such as imprisonment. The SAPS 2018/19 crime statistics reveal that the number of common assault incidents decreased by 207 incidents in 2017/18 in comparison to the previous year. However, the number of common assault cases reported to the SAPS in 2018/19 increased by 5 769 incidents compared to the 2017/18 reporting period.

Victims of assault GBH suffer serious injuries, such as broken bones or permanent body disfiguration, which have severe effects on the health of the victim. An analysis conducted by the SAPS in Gauteng and Mpumalanga shows that the three most common places at which incidents of assault GBH in 2017/18 took place were on the streets, at victims' houses and at places that serve alcohol (SAPS 2018). A study involving a random selection of women in South Africa found that 24.6% of the research participants experienced physical assault from their current partners (Jewkes, Levin, Mbananga & Bradshaw 2002).

Physical violence of children on the pretext of discipline is common in South Africa and is accepted by many as a normal parenting practice. A recent study conducted by Richter, Mathews, Kagura and Nonterah (2018) in Soweto (where Diepkloof, one of the project sites, is situated), which followed more than 2000 children and their families, revealed that physical punishment is widely accepted in South Africa with 60% of the research participants admitting hitting their children with either a belt or other objects. On the positive side, as of 18 September 2019, the Constitutional Court of South Africa declared the "reasonable and moderate chastisement" common law defence as unconstitutional, and effectively banned all

corporal punishment of children.

1.2.1.3 Murder

The SAPS reported that most victims and offenders of murder cases during 2017/18 were males. However, the SAPS also reported that, in 2017/18, there was a notable increase of 12.6% (n=437) in the number of murders of women and children. Due to the increasing trend and ferocious murders of women in South Africa, the government has declared femicide in South Africa to be a national crisis. Based on the 2019/2020 murder cases by the SAPS, 2 695 women were murdered during the reporting year which amounts to seven (7) murders per day. Furthermore, based on the statistics by the SAPS, **a woman is murdered every three (3) hours in South Africa**. In addition, Table 1 below shows that, in 2017/18, murders of women and children contributed the highest number of cases (n=3 915) to the overall murder cases reported in the country. Moreover, the highest number of women and children murder cases (n=886) was reported in KwaZulu-Natal whereas Eastern Cape reported the second highest number (n=730) followed by Gauteng (n=657). Table 1 also shows that, where the project sites are concerned, in the 2017/18 reporting period, the highest number of children were killed in KwaZulu-Natal (n=221), followed by Gauteng (n=108) then Mpumalanga (n=46).

A supplementary analysis of murder cases by the SAPS revealed that an assortment of instruments, such as firearms, knives, other sharp instruments, bricks/stones, blunt objects, bottle heads, poison, fists and feet were used to commit murders in 2018/19. Furthermore, the two most common weapons used during the commission of murder in 2018/19 were firearms used in 7 156 of the cases and knives used in 4 720 cases (SAPS 2019). Abrahams, Jewkes, Martin, Matthews, Vetten and Lombard (2009) report that the most common methods used to kill women in incidents of IPV include blunt force trauma, sharp objects, firearms, strangulation, burning, drowning and asphyxiation.

Table 1: Provincial overview: Murders of women and children 2017/18[3]

Province	Women	Children		Total children (girls + boys)	Total (women + children)	Woman and child murders: % contribution	Provincial murders: % contribution	Total RSA murders: % contribution
		Girls	Boys					
EC	550	43	137	180	730	18,6%	19,1%	3,6%
FS	202	21	31	52	254	6,5%	24,1%	1,2%
GP	549	31	77	108	657	16,8%	15,5%	3,2%
KZN	665	91	130	221	886	22,6%	20,2%	4,4%
LP	184	14	17	31	215	5,5%	23,6%	1,1%
MP	171	16	30	46	217	5,5%	23,5%	1,1%
NW	182	13	36	49	231	5,9%	24,3%	1,1%
NC	57	5	14	19	76	1,9%	22,4%	0,4%
WC	370	60	219	279	649	16,6%	17,4%	3,2%
RSA	2 930	294	691	985	3 915	100,0%	19,3%	19,3%

*Unfounded cases included

Source: SAPS (2018)

According to the SAPS (2018), most murders take place during weekends when people are socialising at home or at places of entertainment, with the associated use of alcohol. Streets or highways were identified as the most common places where murders took place across all provinces in 2017/18. A noteworthy number of homicides took place in taverns or *shebeens*.[4] The comparison of the three project provinces show that Mpumalanga reported the highest percentage (11%) of murders that took place in taverns, followed by Gauteng (3%) and KwaZulu-Natal (3%) (SAPS 2018).

1.2.2 Causes of GBV

The prevalence of GBV in South Africa, as well as globally, is rooted in historical systemic

[3] The 2017/18 stats were used because, in the 2018/19 and 2019/20 SAPS statistics report, murder is not aggregated according to gender, etc.

[4] A tavern or a *shebeen*, in the South African context, is an informal licensed place of consuming alcohol in either a rural or peri-urban area.

gender inequality and discriminatory heteropatriarchal[5] practices that disempower women, girls, and other gender minority individuals. It is widely accepted that there is no simple solution to the question regarding GBV as it is attributed to a plethora of risk or causal factors.

The term "risk factor" is defined as any stimulus that increases the likelihood of offending onset and persistence (Jenson & Fraser 2011; Murray, Farrington, Sekol & Olsen 2009). On the other hand, protective factors are those influences that deter a person from committing crime in the presence of a risk (Herrenkohl, Hawkings, Chung, Hill & Battin 2001). Krug, Dahlberg, Mercy, Zwi and Lozano (2015) explain that GBV is caused by interactions between individual, community, economic, cultural and religious factors. Heise, Ellsberg and Gottmoeller (2002) posit that factors that influence a person at an individual level include growing up in a violent home, having an absent father or the lack of a positive male role model. Young people who grow up in violent homes normalise violent behaviour as a means of communication in their relationships (Holt, Buckley & Whelan 2008). Risk factors associated with an increased risk of sexual victimisation for young people, who participated in the study by Artz et al (2016, p. 11), were: "living with neither or just one biological parent, parental absence either due to hospitalisation or prolonged illness, parental substance abuse, disability status of the child, as well as sleeping density (the number of teens or adults with whom the participant shared a room)."

At a community level, factors that contribute to the perpetuation of GBV are violent neighbourhoods that view violence as a way of resolving conflict, alcohol abuse and gun ownership. Alcohol is one of the multiple generators of crime (SAPS 2019). Even though the consumption of alcohol is not the problem, the abuse of alcohol and/or other substances has a negative impact on rational thinking and behaviour leading to the inability to resolve conflict in a peaceful manner (SAPS 2019). Societal factors include poverty, unemployment, and the lack of economic independence among women (Centre for the Study of Violence and Reconciliation [CSVR] 2016). It is important to note that poverty, in itself, does not cause crime. The impact of poverty on crime involves a complex interrelationship between several variables on an individual and community level.

While it is important to focus on factors that cause GBV to understand the etymology of the

[5] Heteropatriarchy represents a society or culture dominated by the ruling class of heterosexual men.

crime, it is as important to identify protective factors that play a role in the offsetting of the violence. Protective factors associated with a reduced risk of sexual victimisation include parents' knowledge of with whom and how their children spend their time, and where they go (Artz et al 2016). Moreover, warm and supportive relationships between parents and their children were found to be associated with lower risks of sexual victimisation (Artz et al 2016). Thobane (2014) posits that:

> "… families, schools and communities [should] promote protective pro-social behaviours such as helping, sharing, and cooperating, while antisocial behaviours (aggressive and oppositional behaviours) [should be] discouraged. Through formal programmes in the family, community, crèche and at primary school level, children [ought to] be taught at a very young age to be proud of upholding pro-social behaviours" (p. 207).

1.2.3 Impact of GBV

As explained by Mpani and Nsibande (2015), GBV, as both a human rights and public health issue, does not only affect the individual but also has an impact on the survivor's family, the community as well as the government. On an individual level, the effects of GBV include physical harm such as bruising, broken bones, chronic pain, headaches, unwanted pregnancy, miscarriage, early labour or injury of a foetus in a pregnant woman, or death (Mpani & Nsibande 2015). Experience of GBV can lead to mental health problems such as post-traumatic stress disorder (PTSD), depression, anxiety, phobias/panic disorders and behavioural effects such as alcohol abuse, suicidal thoughts, low self-esteem, lack of confidence, living in fear and making excuses for the abuse. Research has revealed that childhood sexual abuse has been associated with the development of hostile attitudes, psychological disorders, and alcohol or drug abuse. Artz et al (2016) further report that girls who have experienced sexual abuse are at a high risk of developing sexual behaviours that make them vulnerable to re-victimisation while sexually abused boys are at a high risk of developing risky violent behaviours later in their intimate and non-intimate relationships. One-fifth of children who are sexually victimised by adults are at a high risk of experiencing problems with schoolwork or school attendance (Artz et al 2016).

GBV also bears financial implications for both the survivor and the state. Because of GBV, survivors and their families often seek health care support to deal with the physical and/or

mental harm caused by the crime. Survivors are also at risk of losing their employment due to the harm and suffering caused by GBV. The report by Khumalo, Msimang and Bollbach (2014) entitled "Too costly to ignore – the economic impact of gender-based violence in South Africa" estimates that GBV costs South Africa between R28.4 and R42 billion annually, or between 0.9% and 1.3% of the gross domestic product (GDP) annually (Khumalo et al 2014).

1.2.3.1 Sexual and reproductive health

> "It is impossible to talk about HIV/AIDS without talking about domestic and sexual violence" (Peer educator for Men as Partners Program, South Africa).

VAW is one of the major factors contributing to the ill-health of women as it affects their emotional and physical well-being, which has an impact on their sexual and reproductive health. South Africa is known to have the largest HIV epidemic in the world. The United Nations Programme on HIV/AIDS (UNAIDS 2020) reports that 7.7 million people in South Africa lived with HIV/AIDS in 2018. Moreover, HIV prevalence among the general population (ages 15–49) was said to be high at 20.4%. Prevalence was further reported to be the highest between men who have sex with men, transgender women, sex workers and individuals who inject drugs. Based on the 2012 South African National Prevalence, Incidence and Behaviour Survey, females are disproportionally affected by HIV in comparison to men, with black African females being the most affected (Shisana, Rehle, Simbayi, Zuma, Jooste & Zungu 2012). "Poverty is an overarching factor that increases the disparity associated with HIV prevalence between genders and among race groups created by historical and current unequal cultural, social and economic status in South Africa" (Mabaso, Makola, Naidoo, Mlangeni, Jooste & Simbai 2019, p. 2). The low socio-economic status of women, particularly black women, thus supports gender power inequalities, which compel women to participate in risky sexual behaviours such as transactional[6] sex (Mabaso et al 2019).

A South African study on the associations between IPV and HIV risk behaviour that interviewed 1 275 young men from 70 villages near Mthatha in the Eastern Cape, revealed

[6] As explained by UNAIDS (2018), "transactional sex is not sex work but refers to non-marital, non-commercial sexual relationships motivated by an implicit assumption that sex will be exchanged for material support or other benefits. Most women and men involved in transactional sex relationships consider themselves as partners or lovers rather than sellers or buyers."

that “men who perpetrate IPV engage in higher levels of HIV risk behaviour than non-perpetrators, and suggest further that more severe violence is associated with higher levels of risky behaviour” (Dunkle et al 2006, p. 2110). The latter part of the finding suggests that experiencing only one episode of violence is not associated with an increased level of HIV transmission among women. Furthermore, unequal power dynamics between men and women often make it difficult for women to negotiate safe sex or the use of a condom particularly in an abusive relationship.

According to the United Nations Population Fund (UNPFA n.d.) The following are factors that heighten the risk for both GBV and HIV infection:

- Individuals who have experienced sexual coercion and assault early in their lives are more likely to develop sexual risk-taking behaviour later in life (i.e., unprotected sex with more than one partner or transactional sex).
- Child and adolescent victims of sexual violence are more likely to repeat the cycle of violence, which bears negative health consequences.

Mpani and Nsibande (2015) believe that family planning and modern contraceptives provide women with the choice and opportunity to make informed decisions about their own lives. Through family planning, young women can prevent falling pregnant in their teens or too early in life and thus can reduce the risks of pregnancy complications, or maternal and child mortalities. According to the UNPFA (n.d.), IPV is an obstacle to the use of contraceptives and condoms and thus denies victims their reproductive rights as well as the right to sexual health. Oftentimes women whose partners oppose family planning seek “invisible” contraceptives, such as hormonal injections, that will not be noticed by their partners. Also, women who are victims of GBV may also lack the desire to want more children. Nonetheless, a coercive sexual relationship that does not allow for the negotiation of safe sex may lead to unplanned pregnancies and unsafe abortions.

1.2.4 Prevention of GBV

The South African National Crime Prevention Strategy (NCPS) was initiated in 1995 after an address by the former president Nelson Mandela raising concerns at the opening of Parliament. In his address, Nelson Mandela said:

> "The situation cannot be tolerated in which our country continues to be engulfed by the crime wave which includes murder, crimes against women and children, drug trafficking, armed robbery, fraud and theft. We must take the war to the criminals and no longer allow the situation in which we are mere sitting ducks of those in our society who, for whatever reason, are bent to engage in criminal and anti-social activities. Instructions have therefore already gone out to the Minister of Safety and Security, the National Commissioner of the Police Service and the security organs as a whole to take all necessary measures to bring down the levels of crime" (President N R Mandela, 17 Feb 1995, Cape Town).

In May 1995, a multi-inter-disciplinary team began to draft a long-term crime prevention strategy, now called the NCPS. Besides the criticism levelled against the launch of the NCPS, it introduced a new paradigm for dealing with crime, which included the following approaches:

- Crime cannot be reduced using only law enforcement and criminal justice (CJ) responses.
- For the CJS to function effectively, there needs to be better collaboration between the various departments that constitute the system as well as an integration of crime response and prevention efforts.
- The government cannot deal with crime on its own. Therefore, government departments in all the three tiers (i.e., local, provincial, and national) ought to work with each other as well as with the civil society to prevent crime.
- Crimes are not the same; therefore, specific prevention strategies should be designed for each crime.
- Prevention efforts must be victim-centred and not focused on the perpetrator.
- Crime prevention efforts need to take both the fear of crime as well as real crime patterns into consideration. For the NCPS to be deemed successful, it should be able to reduce the fear of crime as well as the actual crime rate (Rauch 1999).

According to the Republic of South Africa (RSA 2020b), the aims of the NCPS are to:

- Establish a comprehensive policy framework that will enable the government to

respond to crime in a coordinated and focused manner, which draws on the resources of all government departments as well as civil society;

- Promote a shared understanding and a common vision of how South Africa will, as a nation, address crime. This vision should inform and motivate initiatives at both the local and provincial tiers of government;
- Develop national programmes which focus on encouraging government departments to deliver quality services aimed at solving social problems that lead to high levels of crime in South Africa;
- Maximise the participation of civil society in initiating and sustaining crime prevention programmes; and
- Create dedicated and integrated crime prevention capabilities focusing on conducting research and the evaluation of departmental and public campaigns and the facilitation of adequate crime prevention strategies at both local and provincial levels.

The NCPS is based on **four pillars**, namely, strengthening of the CJS, reducing crime through environmental design, the introduction of initiatives that encourage public values and education, and preventing transnational crime. These are discussed below but, for the purpose of this report, attention is focused primarily on pillar one.

(i) Strengthening the CJS

The primary aim of this pillar is to make the CJ process more efficient and effective. Under this pillar, clear strategies that focus on both crime deterrence and the decrease of repeat offending are developed. The focus is to redesign the CJS as a whole to ensure that victims are prioritised in the system. The key aims of programmes under this pillar are to:

- increase the efficiency and effectiveness of the CJS as a deterrent strategy to crime and as a source of relief and support to victims;
- improve access to justice by disempowered groups such as women, children and victims in general;
- focus the resources of the CJS on priority crimes;
- forge inter-departmental integration of policy and management in the interests of

coordinated planning, coherent action and efficient use of resources; and

- improve service delivery by the CJS to victims by being sensitive to their needs (RSA 2020b).

To attain the above-mentioned goal, the Department of Justice and Constitutional Development' s [DoJ & CD] eight key programmes were identified. However, for this study, the focus is only on the Victim Empowerment Programme (VEP) and the Service Charter for Victims of Crime in South Africa (Department of Justice and Constitutional Development [DoJ & CD] n.d.), hereinafter referred to as the Victims' Charter. The Victims' Charter, developed from the NCPS as well as the 1998 National Victim Empowerment Programme, is a vital instrument utilised to promote justice for survivors. According to the DoJ & CD (n.d.), the Victims' Charter promotes justice for all and is compliant with the Constitution of the Republic of South Africa (South Africa [SA] 1996) and the United Nations (UN) Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power (1985).[7] Moreover, the Victims' Charter highlights services which victims are entitled to in terms of their rights where CJ services are concerned in the Minimum Standards Services for Victims of Crime (MSSVC) developed in 2004.[8] Responsibilities and services that must be provided to victims when they present themselves to government departments, such as the SAPS, National Prosecuting Authority (NPA), Health (DoH), Justice and Constitutional Development (DoJ & CD), Social Development (DSD) and Correctional Services (DCS), are all highlighted in the MSSVC. Victims' rights as outlined in the Charter are as follows:

- The right to be treated with fairness and with respect for dignity and privacy;
- The right to offer information;
- The right to receive information;
- The right to protection;
- The right to assistance;
- The right to compensation; and
- The right to restitution (DoJ & CD n.d.).

[7] https://www.ohchr.org/en/professionalinterest/pages/victimsofcrimeandabuseofpower.aspx

[8] https://www.gov.za/sites/default/files/gcis_document/201409/vcms0.pdf

CJS role-players (i.e., SAPS, courts, DCS, NPA, DSD, Metropolice and DoH) are expected to make copies of the Victims' Charter and make them available at their offices.

(ii) Reducing Crime through Environmental Design

The focus of this strategy is to design crime prevention measures in ways that decrease opportunities to commit crime and increase detection and identification of offenders (RSA 2020b).

(iii) Public Values and Education

Pillar three focuses on developing programmes that change the way community members react to crime. Programmes under this pillar focus on education and the sharing of information for facilitating meaningful community engagement in crime prevention (i.e. awareness campaigns, community dialogues, etc.).

(iv) Transnational Crime

Programmes under this pillar are aimed at the prevention of crimes related to cross border trafficking by improving border control (RSA 2020b).

To prevent GBV, South Africa has ratified the Beijing Platform for Action (BPFA), which focuses on advancing the rights of women and gender equality globally. South Africa has also ratified the Southern African Development Community (SADC) Declaration on Gender and Development and the UN Convention on the Elimination of All forms of Discrimination against Women. Furthermore, various legislations dealing with GBV issues are in place, namely,

- Domestic Violence Act, 1998 (No. 116 of 1998);
- Criminal Law (Sexual Offences and Related Matters Amendment Act (No. 6 of 2012));
- Maintenance Act (No. 99 of 1998);
- Protection from Harassment Act, 2011 (Act 17 of 2011); and
- Children Act, 2005 (No. 38 of 2005)

The National Strategic Plan on Gender-Based Violence and Femicide (GBVF-NSP) (RSA 2020d) was developed in 2019 because of the Presidential Summit on GBV which took place in November 2018. The GBVF-NSP was promulgated in 2020 and its purpose is to provide a

unified strategic framework meant to guide the response and prevention of GBV and femicide in South Africa. The purpose of the GBVF-NSP is to "provide a multi-sectoral, coherent strategic policy and programming framework to ensure a coordinated national response to the crisis of gender-based violence and femicide by the government of South Africa and the country as a whole" (RSA 2020d, p. 16).

The GBVF-NSP is built on six pillars, namely,

1. accountability, coordination, and leadership;
2. prevention and rebuilding social cohesion;
3. justice safety and protection;
4. response, care, support and healing;
5. economic power; and
6. research and information management (RSA 2020d, pp. 18–19).

1.2.5 Challenges with the CJS

As shown in the preceding discussion, South Africa has effective policies to address GBV, but the limitation is in their implementation. As a result, victims of crime, GBV included, often experience numerous challenges as they navigate through the CJ process. Challenges faced by the CJS include a lack of resources (that includes police officers and/or stations, trained officials specialising in GBV and vehicles), secondary victimisation of complainants and the high attrition rate of GBV cases.

1.2.5.1 Secondary victimisation

Secondary victimisation refers to "the processes, actions and omissions that may intentionally or unintentionally contribute to the [re-victimisation] of a person who has experienced a traumatic incident as a victim through:

- Disbelief of the person's account;
- Blaming the victim; and
- Lack of (or insufficient) services at interpersonal, institutional and broad social levels to support the victim" (DoJ & CD 2006, p. 2).

The CJ process may cause secondary victimisation to the survivor, starting from investigation, deciding whether to prosecute, the trial, to the sentencing of the offender. Moreover, actions and attitudes by CJS officials, such as a refusal to recognise victims' experiences as a crime because of their cultural group, class or gender, is a complete denial of their rights.

1.2.5.2 Attrition of cases

Attrition in the CJ refers to the difference between the number of crimes committed and the number that ends with a conviction. Attrition can take place during the following stages of the case (Machisa et al 2017):

- At the reporting stage when a police officer may use his/her discretion not to open a case if he/she is not convinced of the reliability of the complainant's statement;
- During the investigation stage when the suspect remains unidentified and chances of locating or arresting him/her are deemed very low to nil; or when the victim is untraceable or expresses disinterest in pursuing the case;
- At the prosecution stage when prosecutors decline to prosecute for different reasons, including lack of or poor evidence;
- Prior to the start of trial, the prosecutor may withdraw the case due to lack of co-operation from the complainant, the disappearance of the perpetrator or other reasons; and
- After the trial has started due to failure to establish a *prima facie* (sufficient to establish a fact) case or other reasons that lead to the case being discharged by the court.

> "Victim withdrawals occur at any stage of the process, often when the case is prolonged. Victims often withdraw cases when they have less confidence in the system to deliver justice and hence wish to 'carry on with their lives'. Many victims also experience social pressure from family members, the community and those known to the accused, which can render the cost of pursuing cases very high for victims" (Machisa et al 2017, p. 20).

In 2003, a study on the attrition of rape cases through the CJS was conducted by SAMRC and CSVR where 2 064 cases reported at 128 police stations in Gauteng were analysed. Dockets

for the cases that went to court were obtained from the two high courts in the province, and 30 magistrates' courts.

The outcomes of the 2 064 cases in the study were as follows:

- Half (50.5%) of cases resulted in arrests but only 42.8% of perpetrators were charged in court;
- Trials commenced in fewer than one in five cases (17.3%); and
- A conviction for any crime resulted in just over one in 20 (6.2%) cases. However, some of these convictions were for lesser charges so, overall, only 4.1% of cases reported as rape resulted in convictions for rape (Vetten, Jewkes, Sigsworth, Christofides, Loots & Dunseith 2008).

In 2003 and 2006, Artz and Smythe conducted two studies. They examined the disposition of 1 600 rape cases across six urban police stations. Artz and Smythe's (2007) analysis of rape cases showed that there are considerable variances between stations and between courts. Their findings showed that attrition goes beyond individual factors and implicates more serious systemic disparities in the management of rape cases (Artz & Smythe 2007).

In 2012, the SAMRC conducted a study on rape justice where 3 952 cases of rape reported at 170 police stations across the country were analysed. Of the 3 952 cases:

- An arrest was made in 2 283 (57%) of cases;
- A total of 2 579 (65%) out of 3 952 were referred for prosecution;
- Prosecutors accepted 1 362 of the cases (34.4%) which were enrolled for trial;
- Trials started in 731 (18.5%) of the cases enrolled; and
- Out of the 731 cases for which trial started, only 8.6% of the original 3 952 (n=340) were finalised, with a verdict of guilty of a sexual offence (Machisa et al 2017).

Based on the above discussion, it is clear that there are challenges with a high attrition rate of cases resulting in fewer convictions. Whilst the annual police statistics indicate high numbers of reported cases, the conviction rates remain very low.

1.3 RESEARCH METHODOLOGY

1.3.1 Research approach

The qualitative research approach was utilised to conduct this research. As explained by Dantzker and Hunter (2012), qualitative research is the non-numerical analysis and interpretation of observations to discover underlying meanings and patterns of relationships, which would otherwise not be revealed through the quantification of data. Conventional research studies often use research subjects to

> "further an agenda outside the needs, benefits and the guidance of the population being researched and often employ oppressive and colonising behaviours such as using indigenous[9] knowledge without permission or for personal gain of which the researched do not benefit" (Snow et al 2016, p. 359).

This research adopted a transformative paradigm that recognises that injustice and inequality are prevalent, and that research should be utilised as an instrument for addressing these social issues. The specific method used in this study was the Khupe's transformative community-based research. Sanchez-Betancourt and Vivier (2019) posit that the community-based approach departs from conventional research because it emphasises collaboration, transformation, and reflection. Community-based research encourages "collaboration between the researchers and communities, therefore validating different sources of knowledge including indigenous knowledge", which is conventionally not validated as (Western) knowledge (Sanchez-Betancourt & Vivier 2019, p. 376). Sanchez-Betancourt and Vivier (2019, p. 376) further explain that community-based research methods are transformative since they allow "experiential learning and problem solving". Moreover, community-based research allowed fieldworkers in this study to approach the communities as learners and not knowers. Consequently, the research subjects played the roles of knowledge producers.

[9] For this research, indigenous populations are the African marginalised members of South African society whose social, cultural, economic, and political characteristics are different from the population that hold Western views.

Figure 3: Khupe's framework for transforming research methodology

Source: Khupe (2020)

Furthermore, this research was collaborative in nature and relationships based on mutual respect were forged between the researchers, the community partner organisations (see section 1.1) as well as the participants. Community partners played a role of elders[10] because of their knowledge of and closeness to research subjects or the communities in which the study was conducted.

Even though participation in this study did not bring direct benefits to the individual participants, their communities may benefit from the research findings as local GBV interventions might be strengthened. Throughout the study, we were mindful of the fact that communities are characteristically diverse and thus the research methodology was context driven. Most importantly, the findings presented in this study are based on the perspectives of individuals who represented their communities. In addition, the research elders also played the roles of cultural guides by assisting the researchers, specifically field workers, to

[10] Elders in the context of this research are individuals who have authority because of their knowledge of the communities in which the study was conducted.

understand and observe cultural protocols that exist in the communities. Since this research was conducted after a thorough and informed mapping of the project sites, the research topic was relevant to the communities that were selected as part of the project. Lastly, during the interviews, participants were encouraged to respond in their native language, which allowed them to better express themselves, in turn, allowing for the collection of in-depth data.[11] As explained by Ngũgĩ Wa Thiong'o (2005, p. 13), language plays a vital role as it "has a dual character; it is both a means of communication and a carrier of culture." Accordingly, when individuals are granted an opportunity to speak in their own language, they are provided an opportunity to both communicate and reflect on personal experiences embodied in their culture. Khupe (2014) adds that language constitutes intellectual and cultural resources for indigenous communities and is key in the transmission of indigenous knowledge.

1.3.1.1 Sampling method

Eighty (80) individuals from 40[12] organisations were sampled from a Masiphephe Network overall population of approximately 195 individuals and 148 organisations across the three provinces and six communities. Stratified sampling was utilised to sample participants for this study. This sampling method is used when the population has mixed characteristics to ensure that every characteristic is proportionally represented in the sample. The population is divided into subgroups or strata based on the relevant characteristics. The Masiphephe Network, in each of the project sites was, at the time of this research, subdivided into three task teams or strata, namely, CJ, Community Response (CR) and Social Behavioural Change Communication (SBCC). To sample participants from the three strata, the community partners in each of the project sites assisted with the selection process to ensure that the sample represented the characteristics of the overall Masiphephe population. In addition, from the six networks, we selected the sample using purposive sampling.

[11] This was done mainly in five of the six project sites (KwaNdengezi, KwaMashu, Mbombela, Emalahleni and Diepkloof) where the interviews were done with a researcher who understood the local vernacular.

[12] Organisations that repeat themselves across sites were counted as one organisation. However, if the organisations that repeat themselves at all project sites (i.e., the SAPS, DSD) are counted individually, the total is 61.

Table 2: The number of research participants per site

Site Name	Total number of participants
Alexandra (ADAPT)	25
Diepkloof (SONKE)	08
Emalahleni (PSASA)	13
Mbombela (PSASA)	10
KwaMashu (GDF)	11
KwaNdengezi (ECC)	13
Total	**80**

Purposive sampling takes place when study participants are chosen to be part of a study with a specific purpose in mind since the researcher believes they possess the characteristics of individuals who have knowledge about a topic at hand. In addition, the research sample was selected in such a manner that the different types of organisations dealing with issues of GBV in the communities (i.e., government departments/statutory service providers, Non-Profit Organisations [NPOs] and Community Based Organisations [CBOs]) were represented in the research.

1.3.1.2 Data collection

Two forms of in-depth qualitative data collection methods, semi-structured interviewing and a focus group discussion (FGD), were utilised to collect primary data from the 80 stakeholders[13] who took part in this study. Face-to-face, semi-structured, one-on-one interviews were conducted with 46 participants across four project sites;[14] 21 participants from Alexandra and Diepkloof were interviewed individually over the telephone; two (2) participants (from Mbombela and Diepkloof) self-administered their one-on-one interviews by completing an interview schedule electronically; one (1) stakeholder from Diepkloof did an interview via ZOOM; and one focus group (FG) comprising 10 social workers from ADAPT

[13] Stakeholder either means a participant or participating organisation.

[14] KwaNdengezi, KwaMashu, Mbombela and Emalahleni.

was facilitated in Alexandra. The use of a FGD as a data collection method in Alexandra was attributed to time constraints. In addition, due to service delivery protests that took place during April and May 2019 in Alexandra, some data in the area were collected telephonically. The plan to commence empirical research in Diepkloof coincided with initial stages of the Corona virus (COVID-19) in mid-March 2020 when the government, in response to the drastic spread of the virus, announced the national lockdown. Various lockdown restrictions, including travel bans for both personal and business reasons, were imposed that led to the telephonic or ZOOM interviews of seven (7) participants out of eight (8) in Diepkloof while the eighth participant opted to self-administer the interview guide. Data collection for all six sites took 15 months (one year and three months) from April 2019 to July 2020.

In all the interviews, an interview schedule with pre-determined questions was used to guide the interviews and not to dictate, as participants are different. Even though the interview guide was developed in English, participants were encouraged to speak in their vernacular if they felt they could express themselves better in their own language. The fact that a researcher, who understands most of the South African official languages, conducted the interviews in five of the six sites was an added advantage since, where necessary, the questions were explained in research participants' home languages. On the other hand, there was a possibility that some meaning may have been lost in translation thus posing a limitation to the research. To enable the researchers to focus on the interview rather than taking extensive notes, which can be a distraction to both the interviewee and the interviewer, all interviews were audio recorded. Other insights were picked up during the Masiphephe Network workshops. Secondary data were collected from the literature.

1.3.1.3 Data analysis

The data collected were analysed using thematic analysis. The first step entailed transcribing the audio recordings verbatim. Interviews conducted in the vernacular (Sesotho, isiSwati and isiZulu) were simultaneously translated into English by two researchers, who speak and understand the languages, during the transcription process. Furthermore, a deductive thematic analysis approach (Braun & Clarke 2013) was followed where the first phase involved familiarising ourselves with the data through listening to the audio recordings carefully and reading the transcripts repeatedly. The second phase involved generating initial codes from the transcribed data followed by the construction of initial latent themes from the codes after which similar and different codes were compared. The fourth phase involved

defining and refining identified themes, which led to the fifth phase where final themes as well as sub-themes were generated. The transcripts produced three main themes (local GBV networks, access to justice, and risk factors and support structures); each of these themes were accompanied by sub-themes (refer to Chapter 2). The final phase of the analysis process entailed writing this research report. NVivo, a qualitative data analysis (QDA) computer software programme, was used to analyse the data. To ensure trustworthiness of the findings, brief fact checking follow-up interviews were conducted over the telephone with some of the research participants as well as project managers from the community partner organisations.

1.3.1.4 Ethical practices

The ethical clearance for the project (Masiphephe Network) was granted by the UCT's Health Sciences Faculty Human Research Ethics Committee. Moreover, the following ethical practices were maintained throughout the research process:

(i) Informed consent and voluntary participation

Permission to conduct interviews was sought by obtaining consent from each research participant through an informed consent form. Each participant took part in the research voluntarily as we ensured that the informed consent form was detailed, clear and contained adequate information about the purpose of the project and the nature of the study. In addition, participants were requested to read the informed consent form carefully and to ask for clarity if necessary. Finally, after the interviewee indicated that he/she fully understood the content of the form, the consent form was signed and dated by both the researcher and the participant.

(ii) Risks and discomforts

The primary goal of research is to discover knowledge not previously known or to verify existing information, which can, in most instances, be done without inflicting harm to research participants. However, research has a potential to be either physically or emotionally harmful towards participants. It was highlighted in the informed consent form that, because GBV is a very sensitive topic, some of the information shared by participants may cause discomfort. As a result, participants were granted the opportunity to discontinue participation if they felt that carrying on with the interview would expose them to any form of risk or danger. Furthermore, participants were assured that they would not be asked to

share any personal information or confidential information about their clients. To further minimise risks and discomforts caused by the research, participants were reminded of their right not to answer any question they felt would make them feel uncomfortable.

(iii) Benefits

It was made clear to the participants, both verbally and through the consent form, that participation in the research would not bear any direct benefit to them. Nevertheless, it was explained that their participation might inform GBV interventions to strengthen community governance and accountability; to improve primary, secondary and tertiary GBV prevention approaches; and to increase access to justice for GBV survivors.

(iv) Confidentiality and anonymity

Confidentiality and anonymity are two important ethical issues where social research or research involving human participants is concerned. Confidentiality was protected throughout this study by ensuring that confidential information shared by the research participants was only available to the GHJRU research team. All hardcopy documents containing confidential information (i.e., consent forms with participants' signatures) were stored in lockable cupboards and only the team had access to them while electronic data were stored in researchers' password protected laptops and on the cloud. Only the GHJRU research team had access to this information. Even though complete anonymity could not be maintained because the fieldworkers had face-to-face contact with the research participants, either during workshops or data collection, partial anonymity was ensured by not publishing any of the participants' names in this report. As a result, information provided in this report cannot be traced back to specific participants. Names are further omitted from the verbatim responses used to accentuate the research findings.

1.4 STUDY LIMITATIONS

1.4.1 Access

As expected, some cancellations of interviews took place across all sites. Moreover, permission to conduct the interviews was denied by some organisations. As a result, samples in some of the communities were not a good representation of the organisations involved in

the Masiphephe Network in the specific sites.

1.4.2 Limited knowledge of GBV

It was realised during workshops as well as in the in-depth interviews that some participants, particularly those coming from CBOs and NPOs, had limited knowledge of GBV issues. Consequently, their limited knowledge of the topic led to their interviews being concise and lacking important details. Language could have been a possible barrier as some participants may have not been able to fully express themselves in English, during interviews which were conducted in English. To counteract the latter, the researcher at five of the six sites was able to speak most of the South African languages and thus allowed interviewees who were not conversant in English to do their interviews in their mother tongues. The same approach was adopted during the workshops. Additionally, in KwaMashu, a colleague from the community partner (GDF) attended some of the interviews to assist with the translation of questions participants may have found difficult to understand.

1.4.3 Self-reported data

Data were collected from 80 participants across three provinces using semi-structured interviews and the FGD method. Consequently, data were self-reported. Self-reported data have limitations in that they can rarely be autonomously verified. Four self-reported data biases should be noted (University of Southern California 2020): (1) **selective memory** (remembering or not remembering certain experiences); (2) **telescoping** (remembering certain events that happened at one point in one's life as if they took place at another time); (3) **self-serving attributional bias** (the tendency to attribute positive events to personal factors or to one's personal agency and attributing negative events or failures to factors out of one's control); and (4) **exaggeration** (reporting events greater than they really are in real life or in comparison to existing data). Nevertheless, the above-mentioned biases were reduced through interviewing multiple participants allowing for comparison of the interviews for similarities and contradictions.

1.4.4 Findings not statistically representative or generalisable

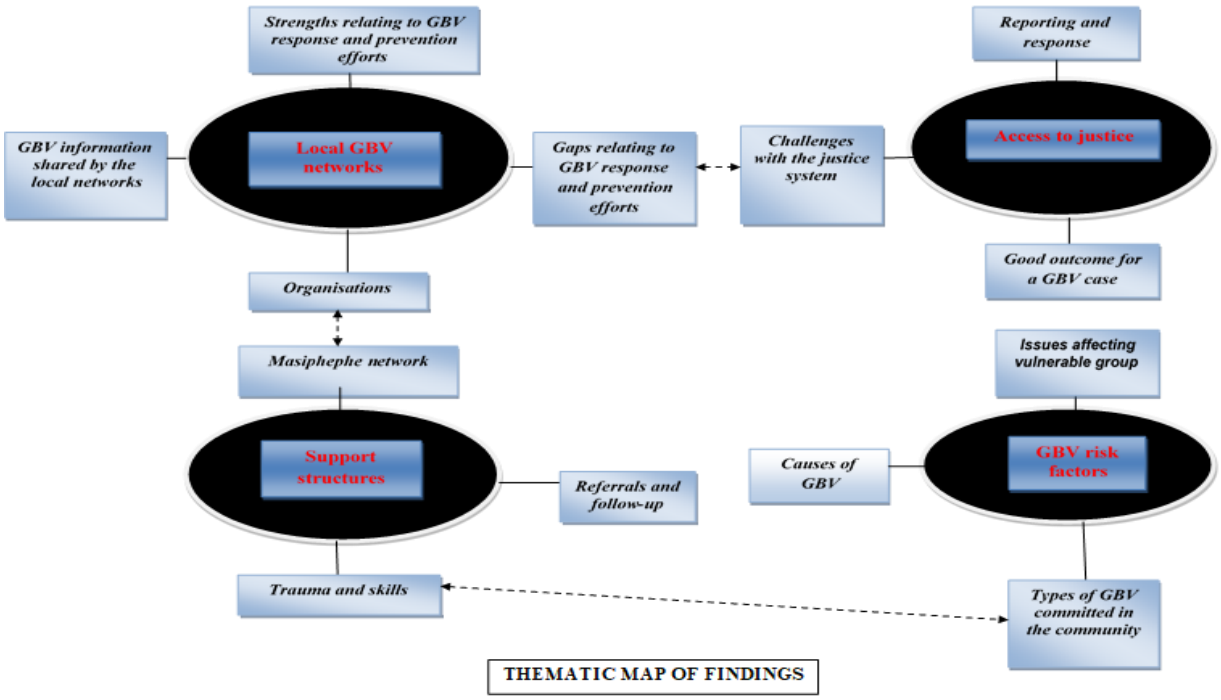
The aim of a qualitative study is to gain a deep understanding of a specific phenomenon or topic based on the perspective of research participants rather than focusing on numerical

data and generalising findings across the entire population. To collect in-depth qualitative information, data are collected from only a few individuals while quantitative statistical tests require larger sample sizes to meet requirements regarding population representativeness, which allows findings to be generalised. This study was based in three provinces and six communities with a sample of only 80 participants. As such, the results from this research cannot be generalised to the larger population in the provinces where the research took place, specifically, or South Africa, in general. On the other hand, the results of this study might provide an in-depth understanding of the phenomenon of GBV and may possibly be used as a guideline when evaluating current response and prevention efforts utilised in the research sites. Research results from this study may also inspire a rollout of a similar project in other provinces and communities across the country and even outside South Africa.

1.5 EXECUTIVE SUMMARY OF FINDINGS

Findings in this report are categorised into four main themes, namely, local GBV networks, access to justice, GBV risk factors and support structures.

Figure 4: Thematic map of findings



1.5.1 Local GBV networks

Eighty (80) individuals from 40 organisations took part in this study. Overall, there was a good representation of both statutory and civil society organisations dealing with issues of GBV at local government levels. The findings show that most of the organisations represented in the Masiphephe Network deal with crime prevention at either primary (i.e., awareness campaigns, community outreaches and dialogues) or secondary levels (victim empowerment services – medico-legal, psychosocial). However, there is an under-representation across all six sites of both statutory and non-statutory organisations that deal with crime prevention at a tertiary level (i.e., courts, DCS, diversion programme organisations). Even though the collaboration of efforts was evident across all project sites, two challenges that hamper collaboration were identified, namely, a disconnection between stakeholders working in silos and the lack of political will. It was further reported that poor attendance at GBV programmes, withdrawal of cases by victims, unsafe communities, and interference with the law enforcement by traditional and/or community leaders are some of the barriers faced by organisations that render GBV response and prevention services.

Gaps relating to GBV response and prevention efforts ranged from the lack of resources (such as training, police vehicles, police stations, sexual assault comfort packs and funding for NPOs and CBOs) and services, particularly by statutory organisations that are located far away from the community.

The common strengths across all three provinces were the collaboration between various stakeholders and the Thuthuzela Care Centre (TCC) (RSA 2020c), a one-stop centre (OSC) model, which reduces re-victimisation by ensuring that all the services required by survivors of sexual offences can be found in one place. Secondary victimisation, socio-economic issues, harmful cultural/social norms, personal safety, and the distance of police stations from the community were all pointed out as reasons why people do not report GBV.

1.5.2 Access to justice

Challenges experienced with the justice system (the police and the courts) ranged from structural racism, language as a barrier, police corruption, lack of training to deal with GBV cases, withdrawal of cases and cases being struck off the court roll.

When participants were asked what justice in a GBV case means, the common response was that justice means different things to different individuals. To one individual, it may mean a conviction or a harsh correctional sentence, while the next individual may feel that justice in a GBV case is served after receiving holistic victim empowerment services, which facilitate healing. In addition, justice could mean a combination of the former and the latter.

1.5.3 GBV risk factors

Domestic violence (DV) against women, specifically intimate partner violence (IPV) (i.e., rape and physical, emotional, verbal or financial abuse) was reported as the main GBV crime experienced in the communities. After women, children were said to experience various forms of DV, such as neglect, physical abuse, and sexual abuse, where perpetrators are usually male members of the family such as brothers, fathers, stepfathers or uncles. Participants in KwaNdengezi and Diepkloof reported sexual grooming of young schoolgirls by taxi or scholar transport drivers who, after impregnating the girls, abandon the mothers and the children. Where vulnerable individuals are concerned, rape of both children and adults with mental disabilities was reported. Financial abuse (i.e., withholding of a pensioner social grant) of the elderly by grandchildren was reported. Members of the LGBTQIA+ community were said to suffer mostly from harassment (i.e., being called derogatory names such as *stabane*) and homophobic or transphobic rape. Participants admitted that improvements need to be made on support services relating to vulnerable groups, especially people with disabilities and the LGBTQIA+ community.

As in previous studies on GBV, this research found that no single **risk factor** causes violence, but rather a plethora of reasons are associated with violent behaviour. The ecological model by Heise (1998), which presents GBV risk factors at the individual, family, community and society levels, was utilised to determine the causes of GBV across the project sites.

On an **individual level**, it was found that children learn violence in their violent homes. Additionally, the over consumption of alcohol, by either one or both parents, often leads to conflict in the family.

Risk factors at the **family level** were identified as follows: being raised by a single parent, abuse of alcohol by one or both parents, disagreements between parents about child rearing and discipline and neglect of parenting responsibilities by the male parent.

The over consumption of alcohol and high levels of unemployment were identified as the main risk factors at a **community level**. Participants further raised a concern about the large numbers of taverns or *shebeens* in their communities, especially those that do not abide by the Liquor Act 59 of 2003. It was reported that some of these liquor outlets operate illegally without licences, ignore operational hours, or sell alcohol to children. The latter was identified by participants in KwaNdengezi and KwaMashu as a contributing factor to the underage consumption of alcohol in their communities. It was further reported from these two sites that young people also abuse other substances such as *woonga*, *nyaope*, Xanax (antidepressant) and *incika* (a mixture of Sparletta Sparberry soft drink and Codeine, an over-the-counter cough syrup).

On a **societal level**, it was emphasised that harmful sociocultural norms play a significant role in the cause and perpetuation of GBV.

1.5.4 Support structures

The following were the general findings regarding referral and follow-up systems across all project sites:

- The lack of communication within the local GBV networks makes the referral and follow-up of cases challenging and inefficient. As a result, cases may be withdrawn due to a long chain of referrals and a lack of coordination between the service providers.
- Except for the TCC and DSD, where survivors are seen for prolonged periods, most organisations participating in the Masiphephe Network do not have follow-up systems to monitor and evaluate the services provided to survivors.

The study revealed that service providers working with GBV are highly susceptible to secondary trauma. While statutory service providers reported having access to psychosocial services, a considerable number of participants who work for CBOs and NPOs reported that they did not have access to any trauma and burnout services.

The chapters that follow provide detailed discussions of the research findings, as summarised above, under four themes, namely, local GBV networks, access to justice, GBV risk factors and support structures.

CHAPTER 2

2.1 LOCAL GBV NETWORKS

This theme focuses on the work done by the organisations from where the research participants were accessed and how the organisations deal with matters related to GBV as well as collaborative efforts between local networks. Therefore, the following sub-themes will be discussed in this chapter: organisations that participated in this study; gaps relating to GBV response and prevention efforts; strengths relating to GBV response and prevention efforts; and GBV information shared with communities by the local networks.

2.1.1 Participating organisations

Eighty participants from 40 organisations participated in this research. These organisations can be grouped into three main categories, public sector (n=12), civil society (n=27) and private sector (n=1). The largest category of stakeholders was civil society amounting to 27 organisations under four sub-categories: Community Based Organisations (CBOs) (n=8), NPOs (n=15), Arts, Culture and Sport (n=2), Faith Based (n=1) and Orphans and Vulnerable Children (OVC) (n=1). Additionally, NPOs were the most represented in the research.

In general, measures that address GBV can be divided into response and prevention. The primary focus of response services (i.e., medical help, psychosocial services, and shelter) are reactive in nature and are aimed at providing support to individuals who have already experienced GBV. Prevention efforts are, on the other hand, more proactive in nature and focus on how GBV can be prevented from taking place. Even so, response activities, to a certain extent, play a role in the prevention of GBV or its reoccurrence.

When participants were asked about the roles their organisations play in response and prevention of GBV, the answers fell within three categories, namely, primary, secondary and tertiary crime prevention. Where primary prevention is concerned, the majority of the participants who took part in this study, regardless of the category of organisation they worked for, reported engaging in primary crime prevention approaches or deterrence activities, which take place before GBV is committed.

Table 3: Participating organisations

PUBLIC SECTOR	CIVIL SOCIETY	PRIVATE SECTOR
Statutory Departments	**Community Based Organisations (CBOs)**	**Businesses**
1. SAPS – (FCS Unit, DV unit & Social Crime) 2. JMPD 3. DoJ & CD (Court) 4. NPA (TCC) 5. DSD 6. DCS 7. Local government (City of Johannesburg/Mbombela/eThekwini)	8. CPF 9. DCAG 10. Hlahlindlela 11. Mawethu Community intervention Solutions (Diepkloof) 12. Reach for Life 13. CPW 14. OSS 15. Siyaphambili Community Forum	16. Johannesburg Region E Business Forum
Schools	**NPOs/NGOPs**	
17. ECD - Zamani Pre-School 18. Phakama Combined School	19. Childline 20. City Children 21. Teddy Bear Clinic 22. Child Welfare 23. ADAPT 24. Rays of Hope 25. Lifeline 26. Sizonqoba Gender Equality 27. Rays of Hope 28. Positive Foundation Life (Diepkloof) 29. NOBSA 30. Emmanuel Victim Centre 31. Lungelo Women's Intervention 32. FOVOC 33. KHULISA Social Solutions	
Health Facilities	**Arts, Culture and Sport**	
34. Clinic	35. Grassroots Soccer 36. Isimilo Production	
Research Institutes	**Faith Based**	
37. SAMRC 38. WITS-RHI	39. Traditional Healers 40. Organisation	
	OVC	
	41. Durban and Coastal Mental Health	

Various organisations (both statutory and non-statutory) reported offering victim empowerment or support services such as counselling and/or provision of or referral of victims to places of safety. The TCC was said to play a very vital role where secondary crime prevention is concerned as it offers holistic services such as medico-legal (medical examination of sexual offence victim, assistance to open a criminal case, court preparation and psychosocial services) to victims of rape and sexual offences. Of the 40 organisations, only three organisations, namely, the court and correctional services, and KHULISA can be said to play a role in tertiary crime prevention. The courts play a role of tertiary crime prevention through, for example, offender convictions and meting out sentences such as diversion programmes offered by KHULISA, or a detention sentence administered by the DCS.

2.1.2 Collaboration between local GBV networks

This sub-section focuses on the collaborations between the local GBV networks, which play a role in the response and prevention of GBV in the research sites. It includes the various ways in which the stakeholders collaborate, the challenges faced concerning collaboration of response and prevention efforts, as well as the gaps and strengths where response and prevention approaches are concerned.

Participants across all sites unanimously agreed that the work they do is difficult, and they cannot do it on their own, thus it is important for response and prevention efforts to be coordinated and integrated. When asked about how efforts are currently coordinated, what was common across the sites is the multidisciplinary nature of the TCC one-stop approach that enables various individuals from different organisations to work together towards achieving the same goal of turning GBV victims into survivors (RSA 2020c).

Participants expressed that many **challenges** are faced regarding the coordination of GBV response and prevention efforts. When asked to describe those challenges, the following were listed:

2.1.2.1 Disconnect between stakeholders (working in silos)

Stakeholders in all the sites identified this challenge. The reasons that stakeholders are pulling in different directions is because some stakeholders have a lack of communication, commitment and passion in their work. The participants also emphasised that each

organisation has its own institutional goals to achieve which further perpetuates the disconnection. One participant from KwaNdengezi, one from KwaMashu and one from Mbombela explained that, due to the lack of integration between government departments, services are often duplicated. This was confirmed by the following comment:

> "When it comes to gender-based violence, everybody is doing their own thing; we are not coordinated. Should we be working in collaboration, maybe we …. We have something in common which is GBV so we should meet and see what we can do. Because you find that you end up duplicating. And, by me duplicating, I could have seen another client, you see? Should I have known that this child has already been seen by [another organisation/department] then another client would have come in for that day rather than duplicating? Because you find that sometimes clients come into me and say 'you know I have been doing the very same thing with [someone from another department/organisation]' and I say 'HUH!'" [Statutory Stakeholder]

2.1.2.2 Lack of political will

Participants from KwaNdengezi, Alexandra and Mbombela reported that, even though GBV is at the top of the priority list for national government, there is a "lack of political will" from local government to tackle GBV related issues. They also explained that, when new political leaders take office, they discontinue initiatives started by their predecessors and introduce new projects. This hampers the continuity and sustainability of the programmes. Moreover, representatives from such organisations (mainly government) cannot participate in activities without permission from their superiors. Consequently, if the leader is not interested in a particular programme, the department will not be represented. Also found in the same sites is that the different protocols followed by different departments can be a hindrance for stakeholder coordination.

A lack of other resources, such as funding for NPOs and police vehicles, was also identified as a challenge for the coordination of GBV response and prevention efforts between stakeholders. This issue will be unpacked in more detail under the gaps in section 2.2.

When participants were probed on the challenges and barriers they faced when entering

communities to offer GBV response and prevention services, they revealed the following:

2.1.2.3 Poor attendance of GBV programmes

Participants from Emalahleni, KwaNdengezi, Diepkloof and KwaMashu reported that attendance of programmes, such as outreaches, dialogues and workshops by community members, is poor. Consequently, information is not cascaded effectively and thus the community members lack information on GBV issues and support services. When asked why community members do not attend GBV programmes, the unanimous response was that members of the community expect an incentive in the form of lunch, a cap or a T-shirt, for example, for attending events. Therefore, if stakeholders cannot guarantee that attendees will receive something tangible for participating in the event, the response will be low.

One participant in KwaNdengezi explained that the poor attendance of GBV programmes by community members can be attributed to the **lack of a bottom-up approach**. Institutions and stakeholders dealing with GBV do not get buy-in from communities because they develop and implement programmes without first consulting or involving community members to find out if the programmes will cater for their needs:

> "So, I think, somewhere we are not listening to the community, and we are just implementing our own programmes and then we [are] done." [NPO Stakeholder]

2.2.1.4 Withdrawal of cases by victims

Withdrawal of criminal cases by victims of GBV was mentioned across all sites by both the police and other stakeholders as one of their biggest obstacles. Findings from a USAID commissioned study on Improving Case Outcomes for Sexual Offences Cases Project (ICOP) conducted by the GHJRU showed that 40.8% (n=177) of 434 sexual offence cases from five sexual offences courts situated in the same provinces as the current research project were withdrawn (Heath, Artz, Odayan & Gihwala 2018). However, the former study is not specific about how many withdrawals were initiated by the victim and how many were withdrawn by CJ role-players. When participants in the current study were asked why victims withdraw cases, responses ranged from the victim receiving threats either from the offender, the offender's family, or the community leading to the victim fearing for his/her life. This finding

corroborates reasons found by Machisa et al (2017) during the SAMRC study (section 1.2.1.1). Other reasons reported for the withdrawal of cases by victims included survivors not wanting their abusers to be arrested or detained but to be warned; having talked the issue through which led to a temporary resolution; and the offender being the breadwinner thus the victim fearing that if he/she is found guilty and is sentenced to imprisonment, this will cut off their source of livelihood. These intersect with the reasons why individuals do not report GBV. These reasons were reviewed in the literature (see section 1.2) but will be expounded on later in this section.

2.1.2.5 Unsafe communities

A worrying revelation was the issue of the safety of stakeholders when they enter communities to implement GBV programmes. Some areas, such as KwaNdengezi, KwaMashu and Emalahleni, are deemed crime hotspots therefore it is difficult to deliver GBV services to those communities effectively. All participants from KwaMashu reported that marked official state vehicles were targeted by hijackers in the community. As a result, stakeholders often feared going into those communities using official vehicles. The following quotes summarise concerns regarding safety in Emalahleni and KwaMashu respectively:

> "… also getting to the villages or the squatter camps is so [dangerous]; some areas, like here in Witbank … they are very high in terms of violence. When they see, um, a police van or something … you know so the level of trust in terms of the community and the service provider – it's somehow lacking". [Statutory Stakeholder]

> "It is not safe at all, it is not safe at all because today you will find three other people were killed you know when … is it not last year, 2017, they killed a woman who was the supervisor for CCGs. It's a hostel kind of situation so, in that hostel, they don't care you are a woman, they don't care you are a man, if they want to kill you, they just kill you and there's lot of criminal activities but I go at my own risk …." [Statutory Stakeholder]

> "My point of view, because I have worked with those areas a lot when I was a social worker for Child in Need of Care and Protection, is that most of them, they are informal settlements and some of them, like KwaMashu A

> Hostel, they are regarded as the high-risk areas so actually females are not even supposed to stay in those areas … And most of those areas, you find that most of the people came here from the rural areas. They left the rural areas coming to look for job opportunities and then you find that they just find the females that they can live with in these areas. Then you find that now there is abuse taking place in those relationships …" [Statutory Stakeholder]

The finding above about violence in KwaMashu hostels validates findings of the KwaMashu Community Residential Units (CRU) study by Xulu-Gama (2017), which took place between 2009 and 2011. In Xulu-Gama's research, three reasons are provided for the violence in the KwaMashu CRU. They are:

(i) Insecurity caused by gender tensions

Hostels were developed during the apartheid era under the Natives (Urban Areas) Consolidation Act (No. 25 of 1945) for the purpose of influx control or the control of the movement of black people in urban areas. Historically, women stayed at home to take care of the household and to rear children and hostels were created for men so that they could live close to their workplaces while their families were left behind in the rural areas (influx control). It is for this reason that men in the study by Xulu-Gama (2017) strongly believed that a hostel is a house for men (*umuzi wezinsizwa*) and that women are transitory figures who should not be granted permanency in hostels. It is for this reason that most men who lived in the hostels rejected the CRU programme, initiated during the mid-1980s, of converting hostels into family housing. The aim of the CRU programme was to facilitate secure and stable rental occupancy for low-income individuals and households earning between R800 and R3 500 per month (RSA 2020a). Women and children thus started living in hostels through the CRU programme. Still, women staying in the KwaMashu hostel were not completely welcomed by everyone and this caused tension among the hostel dwellers. Firstly, men blamed women for the increase in unemployment for men living in the hostel because they felt that women were more likely to be employed than men while women felt the same about men (Xulu-Gama 2017). Secondly, the author explains that men were adamant that the high crime rates in hostels could be linked to young men's romantic involvements with the women who visited them at hostels. Lastly, men felt that "women were claiming the hostel space as their own and also taking away the privacy of men" (Xulu-Gama 2017, p. 6).

The main dispute arose because women were being allocated spaces in the new family CRUs before men who felt they should have been a priority as they had lived in the hostels before the women (Xulu-Gama 2017, p. 6). Xulu-Gama (2017) further found that women who lived in the hostels blamed their victimisation and abuse by men on their decision to live in a space meant for men. The most disturbing revelation was that, if a woman got involved in a romantic relationship with more than one man, the man "who finds out first about the other, will get the gun and kill the other one" (Xulu-Gama 2017, p. 6). Women were subsequently blamed for the murders as it was believed that they were "not behaving themselves" (Xulu-Gama 2017, p. 6).

(ii) Insecurity caused by criminality

Xulu-Gama (2017) explains that hostel residents revealed that they were afraid of being targeted and that their anxiety rose when they heard gun shots in the hostel. Furthermore, hostel dwellers in this research believed that violence in their space was random and anyone could be a victim. However, Xulu-Gama (2017) mentions that some residents believed that the violence in the hostel was rooted in power games where the one holding the power was targeted by those who felt they should have been at the forefront of hostel activities that included the allocation of rooms and the choosing of families that should be allowed to stay in the hostel (Xulu-Gama 2017). It could thus be said that violence and disorder in the hostel can be attributed to a combination of criminal and political motivations. The SAPS names this as one of the reasons for the high 2017/18 murder rates in KwaZulu-Natal (SAPS 2018).

(iii) Insecurity caused by political climate

Historically, "the KwaMashu hostel is known as a place of war between political parties" (Xulu-Gama 2017, p. 7). Xulu-Gama (2017) posits that, even though this particular hostel has a history of being an Inkatha Freedom Party (IFP) stronghold, members of other parties, such as the ANC, lived in the same space and resisted authority from the IFP that caused tension between the parties. Moreover, the shift in the general political power dynamics in the province has had an impact on the political power in the hostel, which led to IFP members and leaders in the hostels feeling threatened.

2.1.2.7 Interference with the formal justice system by traditional justice systems

Culture refers to the values, beliefs, languages, and practices shared by a group of people. It

is made up of rules, norms, laws, and morals that govern a community or society. Additionally, culture plays a significant role in society because it enriches people's quality of life and improves the general welfare of both individuals and the community. There are many positive cultural practices that are socially beneficial and can be used to prevent GBV. These include social or cultural norms,[15] which promote unity and equity in communities. One such practice is the African philosophy of *Ubuntu*, meaning humanity. *Ubuntu*, translated as: "I am because you/we are", emphasises the importance of how people treat each other and encourages people to live cohesively as a collective.

Even though there are many positive cultural or social norms that can be used to respond to and/or prevent GBV, there are equally numerous harmful sociocultural norms, which perpetuate GBV. In Mbombela, KwaNdengezi and KwaMashu, community and traditional leaders (*IziNduna*[16] or Chiefs) interfere with the formal justice system, especially in the rural areas. A person cannot gain access to the community without first going through the community or traditional leaders. Participants reported that community leaders go to the extent of preventing law enforcers from entering the community to investigate serious cases of GBV, such as incidents of rape against children, as it is believed that issues in the community can be resolved without involving the formal justice system. This is attributed to the cultural norm that a person "should not air their dirty laundry in public" and was translated into isiSwati by one of the participants in Mbombela as: "*Tibi tasekhaya atikhishelwa ngaphandle."* Law enforcers are exasperated about traditional leaders meddling with the law, the inappropriate sanctions, which do not match the severity of the crime, that are imposed on the offender, and the lack of support and justice for the victim.

> "We find that, at the end of the day, a person will just be fined a cow but, after that, nothing is happening to the victim. The victim is not given the support, NOTHING!" [Statutory Stakeholder]

While traditional leaders may be of the view that law enforcers make a mockery of their

[15] Paluck and Ball (2010 cited in Mackie, Moneti, Shakya & Denny 2015) believe that "a social norm is what people in some group believe to be normal in the group, that is, believed to be a typical action, an appropriate action, or both."

[16] *IziNduna*, plural for *Induna*, is a Zulu title for advisors, leaders or headmen who act as a bridge between the community and the King.

culture and undermine their authority, law enforcers in this research believed that traditional leaders need to understand that culture has its place but also has its limits, especially when it comes to issues of violence.

2.2 GAPS RELATING TO GBV RESPONSE AND PREVENTION

This section identifies the various gaps concerning response and prevention of GBV as reported by stakeholders.

2.2.1 Gaps relating to government stakeholders

2.2.1.1 Lack of resources

The lack of resources was cited by statutory stakeholders from all sites as one of the barriers that prevent them from delivering GBV services effectively. These include shortages of trained police officials, police stations and police vehicles.

(i) Lack of police officials trained to deal with GBV

According to the participants, most police officials (especially at station level) lack training and knowledge on how to handle GBV cases. This is one of the reasons why most victims of GBV experience secondary victimisation when they report their cases at the police station. This finding correlates with what was found in the literature. The main points of contention raised that are evidence of the lack of training of police officers include statement taking, secondary victimisation and incorrect completion of the medical examinations in order to complete the SAPS 308 form.

(ii) Shortage of police stations

In Mbombela, KwaNdengezi and Alexandra, community members must often travel long distances to access police stations. It is thus recommended that the local government in these areas consider including satellite stations in their Integrated Development Planning (IDP) to improve access to police stations and, in turn, access to justice, for the affected community members (see section 3.1)

(iii) Limited police vehicles

All police officials, who participated in this study, reported that the lack of police vehicles prevents a swift response to cases of GBV. Also, in KwaNdengezi and Mbombela, when police vehicles are booked for services, they are only returned a week or more later as there is usually only one workshop that services the vehicles in the area. A lack of police vehicles also hampers the coordination of GBV response efforts by different stakeholders. This extends the victim's wait at the Client Service Centre (CSC) at the station which has a negative impact on the victim who needs to be transported to a TCC to receive further services such as medical examinations and psychosocial support and also perpetuates secondary victimisation.

> "The waiting period. You know, when they go to the different places they need to go to. Let's say, if you go to SAPS, there are no vans. So they will wait for hours. And imagine, this person is waiting for hours and he/she is hungry. It's understandable. However, we need to understand the situation the victim is in. She has not bathed. So we need the evidence. She is waiting long, she's hungry, we don't have comfort packs here, we have nothing! So a person ends up giving up and they leave. And there is no one who is here 24/7 to ensure that our victims get the necessary support that they need. Like, just to tell them to please wait a bit while we are waiting for transport, please be patient. So they go back home frustrated by the waiting and regret even going to the police station." [NPO Stakeholder]

The verbatim response above also touches on the issue of the attrition level of GBV cases (see section 1.2.5.2), which is dealt with in the sub-section which deals with services being far from the community under gaps relating to CBOs and NPOs (section 2.2.1 (vii)).

Still on the issue of the lack of vehicles, there was, at the time this research was conducted, no vehicle that was dedicated to the TCC at the RK Khan Hospital situated in Chatsworth, KwaZulu-Natal. Officials at the centre were expected to go into communities to conduct awareness campaigns, but they did not have the means in the form of transport to reach communities. In addition, the TCC officials were unable to fetch victims who did not have their own transport but had to rely on colleagues from the SAPS Family Violence, Child Protection and Sexual Offences Investigation Unit (FCS) Unit to bring victims to the centre. However, police officials (FCS officials included) whom TCC colleagues rely on for transportation of

survivors also reported the shortage of vehicles in their department as one of their challenges. As a result, it was revealed that the TCC officials at RK Khan Hospital sometimes resorted to using their own personal vehicles to render services to the community. One participant in Diepkloof had the following to say about TCC:

> "TCC has a great idea but, in practice, is it not working. It is only in the hospital and there are no satellite offices. We create structures but do not maintain [them]." [NPO Stakeholders]

In conjunction with the above response, the extension of TCC services in primary health care facilities (clinics) is unpacked under the sub-section that deals with services being far from the community under the gaps relating to CBOs and NPOs (see section 2.2.1 (vii)).

(iv) Lack of psychosocial services

A statutory stakeholder interviewed in Emalahleni and another one in KwaNdengezi revealed that they struggled when there was a need for a further referral of survivors requiring more intensive psychotherapy by a psychologist. Two reasons attributed to this challenge were the limited number of psychologists working in public hospitals and the exorbitant consultation fees charged by psychologists in private practice.

> "… there should be something which must done regarding this. Yes, they are private practices, like, we know that there's private hospitals, but there is a general hospital for the people who do not have money, who are earning low. They know we go to a public hospital to be attended for service like this. There must also be services which are provided by the government for the very poor people and those services must be effective. Not that you go there, you wait for three months, you are emotionally broken, then I must wait for three months to get a slot …" [Statutory Stakeholder]

> "Ja, most of our psychologists, they are in the money-making business, they are doing private practice. So, personally, I tried to go around the whole of Witbank trying to engage psychologists telling them that we will pay you … you see, but we won't be able to pay what you request because it's too much … and we [are an] NPO, because they can charge like round about R2 500 per session for one child …" [Statutory Stakeholder]

> "Because, when you are supposed to go out to investigate cases, you have a docket at hand, you want to go out to investigate, you find that vehicles are at the garage [for repairs]. Sometimes, maybe they might take long waiting for parts, sometimes it's been outsourced, those kinds of things. So, ja, in most of the times, it's the issue of resources that can be a barrier to us when it comes to addressing gender-based violence. Resources can also include human resources like those specialised units like the FCS. (Participant 1 interjected: 'Like now, we don't have vehicles. We don't have vehicles, we don't have members [police officials trained to deal with GBV] to assist.') Members and vehicles are the barriers so far within our organisation and the unit." [Statutory Stakeholder]

(v) Shortage of comfort packs for sexual offence survivors

Two participants, one from KwaMashu and one from Mbombela, highlighted that there were not enough comfort packs for survivors of sexual crimes at TCCs. One of the participants further suggested that comfort packs should not only be provided to survivors at TCCs but also be made available at police stations and clinics. This is emphasised in the responses by the two participants:

> "And secondly, we need more comfort packs, because there are some incidents that are bad. My colleague will agree with me, you find that this person was coming back from work and this guy comes and drags them into the bush. Obviously, someone will use force on you, they will tear your clothes, and they will drag you anyhow. And immediately, you will come to the police station and when you come your clothes will be torn and you will be soiled and all of that. So we need packs that consist of sanitary pads and, you know, few toiletries so that you can take a bath, including clean underwear. Because, most of the time, when a case is new and you come in still in those clothes, the forensic nurses also pack the underwear that you are wearing because obviously there is semen and it will be trapped in it. So they obtain it as evidence. So you cannot go home like that, you need something clean. So we need more packs, we don't have enough of those." [Statutory Stakeholder]

> "You know, when they go to the different places they need to go to? Let's say, if you go to SAPS, there are no vans. So they will wait for hours. And imagine this person is waiting for hours and he/she is hungry. It's understandable, however, we need to understand the situation the victim is in. She has not bathed. So we need the evidence. She is waiting long, she's hungry, we don't have comfort packs here [at the clinic or police station], we have nothing." [Statutory Stakeholder]

Comfort packs typically contain toiletries, a snack, underwear, sanitary towels and a small gift or reading material for the survivor (Networking HIV and AIDS Community of South Africa [NACOSA] 2015). As explained by NACOSA (2015), the first responder to a sexual offence case must provide a comfort pack to the survivor as well as a referral to a variety of support services. The purpose of a comfort pack is to provide a sexual offence survivor with essential items required to assist him/her during the initial reporting of the crime. When both the statement and the medical examination is complete, then the survivor can use the essentials provided in the comfort bag to clean up and all clothing containing Deoxyribonucleic Acid (DNA) evidence is kept by the police. In a case of the latter, it is also necessary for clean clothing to be provided to the survivor.

(vi) Lack of sexual assault (evidence collection) kits at TCCs

Very few criminal offences require an examination and collection of evidence as extensive as that required from a sexual assault crime (Acino Forensics 2020) therefore, evidence collection kits are critical tools in a sexual assault investigation. The importance of having sexual collection kits at the TCCs was explained by one of the Site Coordinators:

> "Another thing, there is evidence collection kit, which is brought by SAPS when there is a victim. We used to have it here but recently, since, I think in December, they have been telling us that: 'No! When a victim comes, a victim is supposed to come with their own evidence collection kit from the SAPS'. So it becomes a challenge for us because some of the victims are brought here without a kit. And then you would ask the police officer to collect the kit at the police station and they will take hours. Which also will hinder the victim's life because the hours [72 hours] lapse. So those are the challenges we normally have."

The above response by one TCC Coordinator reveals that, sometimes, victims are unable to access services, such as a medical examination, within 72 hours after being raped due to the lack of urgency and coordination between CJ role-players. Another challenge identified by an official employed by the FSC division of the SAPS was **the delay in processing of DNA evidence by the forensic laboratories** which has a bearing on the rape case attrition or conviction rates. Although the SAPS Forensic Science Laboratory (SAPS FSL) is one of the most technologically advanced forensic DNA laboratories globally, it has been accused of delays in processing or finalising DNA evidence:

> "The forensic labs are taking too long to finalise their cases. Because, remember, what happens is that, when a victim comes to report, they are examined and, not only that, there will be specimens that will be collected from them, evidence from them. Then we pack it in the crime kit; sexual evidence collection kit. And then we take it to, we send it to forensic science laboratory and, whenever a suspect is known, we will effect an arrest and also we will collect glucal sample for DNA analysis. So, when we send it there, in the meantime, I'll be doing on my investigation, obtaining statements, doing this and that until the case is complete. The docket will be ready for court and now the stumbling block will be the forensic lab report. They take too long to finalise. Because, I understand it's a case, they need to assign it to someone and they will start doing their own investigation, analysing, writing of report and this and that. Then eventually, they will send it back. They take too long to finalise, and a case can be withdrawn because of that." [Statutory Stakeholder]

The following are identified by Omar (2008) as some of the reasons for delays in the finalisation of evidence:

- Insufficient training of the individual collecting evidence;
- Submission of a partially complete crime kit by the health care practitioner; and
- Crime kits not being stored in a cool place, or the kits not sent to laboratories as soon as possible.

The first two reasons are concurrent to the findings of this study since they were confirmed by two research participants:

> "But, as for the doctors, they are the ones who cause some of the problems that we encounter at court. 'Cos you find that a doctor will say to you, like the other day when I was on standby, 'I am not trained on examining a rape victim.'" [Statutory Stakeholder]

> "And sometimes you go there to the casualty, you ask the doctor to assist you and the doctor tells you they can't examine a case of rape. And then you ask why and then tell you that 'I don't know how to', 'I am an intern', 'I am new'. Or someone will tell you 'No I don't want to be caught up in these cases, I don't want to go and testify in court'. So those are the barriers and challenges that we have." [Statutory Stakeholder]

In addition to the doctors' lack of training to examine a rape survivor, it was reported that some doctors did not complete the J88 form correctly:

> "Some will say, 'I cannot assist because I do not want to be called to the court'. How can you say that, but you are a doctor? Why are you there? And some will come and assist and yet make mistakes and complete J88 incorrectly. 'Cos, once a J88 is completed correctly, there's no reason for the court to call you to testify and clarify some of the things that are missing on J88. But if it's completed correctly, you are trained about this, you know your story; they won't call you. When they call you, it will maybe be because of clarity on something else. Yes. So that is the problem. They need a lot of training, especially the completion of J88. It's a mess. Some are in a hurry; you know how doctors write? So, those are the things. So, if they can receive a workshop or some kind of training only on that." [Statutory Stakeholder]

The J88 form is a legal document, which is completed by a medical doctor, district surgeon or a forensic nurse, to document injuries sustained by the victim of crime where a legal investigation is to follow (Medical Protection 2020). The J88 form is integral in the charge, the soundness of the accusation, the severity of the injuries sustained and the type of punishment or sentence to be meted out to the perpetrator (Medical Protection 2020). As emphasised by Dr Kyle Wilson (cited in Medical Protection 2020), even though doctors may dislike the J88 form, they need to remember that it plays a crucial role in the criminal justice system and may be the only objective information available in the case. Medical Protection (2020) further

highlights the following common mistakes made by medical practitioners when completing the J88 form:

- The doctor asked to complete the J88 is not the same doctor who examined the survivor;
- Notes are not descriptive enough;
- Sizes or approximate sizes of wounds are not noted;
- Not all injuries, including minor injuries, are noted. Minor injuries may show intent, type of weapon used, chronic injuries or abuse;.
- Not being thorough in neurological examination; and
- Lack of understanding of medical terminology.

(vii) Services far from the community

It was found across all the project sites that, while there are services, such as primary healthcare, community care givers (CCGs), police stations, and CBOs, available within the community, most services (especially medico-legal, psychosocial, shelters/places of safety) are not easily accessible to community members. In Mbombela, there was only one forensic nurse at the Kanyamazane clinic providing services to the whole community. In Alexandra, the nearest TCC was in Tembisa, another township, which is 24 kilometres (km) away from Alexandra. However, there was an organisation funded by the DoH near Alexandra, called Medico-Legal, offering the same services rendered by the TCC. The head office for Medico-Legal is in Hillbrow (which is 15.8 km from Alexandra) and there is a satellite office inside the Wynberg[17] Police Station. The services rendered by the organisation are as follows:

- Counselling by either a social worker or a nurse;
- Explaining the medical examination process to the victim;
- Completion of the SAPS 308 victim consent form for medical examination;
- Evaluation and caring for victims of GBV by a forensic nurse, collection and securing of evidence for sexual offences;

[17] Wynberg is a small residential area situated between Alexandra and Sandton.

- Taking of a statement and keeping the victim informed about the case by an Investigating Officer (Investigating Officer) from the SAPS; and
- Placing survivors in shelters/places of safety.

Participants from KwaNdengezi, KwaMashu, Diepkloof and Emalahleni reported that there were no forensic nurses at their primary health care facilities. When a sexual offence case is reported at a clinic, the SAPS FCS Unit is contacted to take over the case and transport the victim to the hospital or TCC to access the necessary services.

In addition, since medico-legal, counselling and shelter services were mostly provided in town, community members were thus required to travel from their areas of residence to access the services. The high levels of poverty and unemployment in the research sites means that survivors often do not have transport fare to access services. According to the research participants, this is also one of the reasons for the high attrition level of GBV cases. To decrease the attrition level, one social worker in KwaMashu explained that she often took money from her own pocket or asked for donations from colleagues to prevent her clients from "dropping out" of their counselling sessions. Another gap associated with the high dropout rate of victims from the CJS was said to be the **lack of effective referral processes between stakeholders** which frustrated victims and their families as they were often sent from pillar to post. See section 5.2 for an in-depth discussion of the referral and follow-up systems utilised by stakeholders that participated in this study.

2.2.2 Gaps relating to civil society organisations

2.2.2.1 Lack of funding

Participants from NPOs and CBOs in Emalahleni, KwaNdengezi, Mbombela and Alexandra reported that they experienced a lack of funding, which resulted in volunteers not being paid and difficulties experienced by stakeholders to pay for venues, for example, to hold meetings or host events.

2.2.2.2 Limited shelters/places of safety

Participants from KwaMashu, KwaNdengezi, Emalahleni and Alexandra identified the limited number of places of safety as a gap:

> "No, they are not [enough]. That's the main issue because they are not. Because sometimes, when you call SAHARA Centre with a request for them to remove a victim, you find that there is a waiting list and they are full." [NPO Stakeholder]

> "Like maybe providing the victim and her children with shelter whilst we are dealing with this issue from a legal point of view. I don't think that even Social Development is effective in that sense. This maybe happens in the suburbs but here, in the rural areas and townships, I don't think service and support when it comes to that is that adequate. I am sure there is still a lot that can still be done in that regard." [CBO Stakeholder]

> "We need shelters to take care of children who live on the streets. We also need rehab centres. We also need more shelters for people who are abused." [CBO Stakeholder]

> "I think, for me personally, working at Alexandra Police Station, one of the biggest challenges that I think ... I was actually talking to one of my colleagues just now about it, that we have few shelters for our clients. Few shelters meaning … if we can't place you, what are we going to do? You have to go back now to the same house that you ran away from because, hey, shelters are full. There are no shelters for you. Unfortunately, there's nothing we can do. I can't take you home as a social worker …." [NPO Stakeholder]

A gap mentioned by one participant in KwaNdengezi, which could be said to be relevant to other project sites, is the lack of support and shelters for male victims of GBV:

> "Gender-based violence affects everyone, women, men and children, so there is a place where children are kept and women but then there is a shortage for the one that keeps a male, the fathers, when they are abused by the women. I wish there could be a centre where men will be kept who are abused, be kept there, receive counselling and get healing." [Statutory Stakeholder]

2.2.2.3 Lack of appropriate training, skills and knowledge of GBV issues by CBOs/NPOs

During workshops, it was noticeable that some stakeholders, specifically CBOs and NPOs, had very limited knowledge of GBV issues:

> "That is a gap to say: let's identify those that are working [on issues of GBV], as much as they have been working but let's train them, equip them with skills and knowledge so that they can do proper work out there. Ja!" [NPO Stakeholder]

This observation was corroborated by research participants in Mbombela, KwaNdengezi, Alexandra and Diepkloof. Participants were concerned that they do not have the proper training and skills to deal with issues of GBV which exposes both the community and survivors to unintended harm.

2.3 STRENGTHS RELATING TO GBV RESPONSE AND PREVENTION EFFORTS

The following section lists the strengths participants identified in their specific sites.

2.3.1 KwaNdengezi

- The TCC OSC model or having different stakeholders/departments under one roof to prevent rape and sexual offence victims being sent from pillar to post;
- Ethembeni Crisis Centre's assistance with counselling and further referrals;
- GBV being one of the priorities on the government's agenda;
- Information on GBV issues and services freely available and accessible;
- Services being close to the community; and
- Stakeholders and organisations collaborating and working together through platforms such as the Operation Sukuma Sakhe (OSS). OSS is also referred to as a "war room", a neutral platform where various stakeholders meet on a regular basis to discuss community issues which include GBV.

2.3.2 KwaMashu

- Collaboration between FCS and TCC ensures immediate attendance to GBV cases and effective support of survivors;
- The police respond quickly to cases when vehicles are available;
- Interdisciplinary team of forensic nurses, SAPS, DSD, Lifeline and Childline for trauma debriefing of GVB victims;
- Male traditional healers have been made aware that there are consequences for sleeping with women they claim to be healing;
- The introduction of new equipment (i.e., transcription/recording and case tracking equipment) at the Ntuzuma Magistrate Court plays a role in the finalisation of cases;
- More clerks have been hired at the Ntuzuma Magistrate Court which has made the court system more effective;
- Commemorative days, such as the 16 days of Activism, are observed by all departments. As a result, during commemorative days and beyond, most departments host events and facilitate programmes related to issues of GBV;
- A buy-in from the community on tackling issues of GBV; many community members want change and are going above and beyond programmes organised by stakeholders to ensure that change takes place. Organisations are getting more experienced in dealing with GBV; and
- The Masiphephe Network project is seen as a strength for the community.

2.3.3 Mbombela

- The police station is easily accessed by community members;
- The Greater Rape Intervention Project (GRIP) has a counsellor situated at Nelspruit hospital and in the TCC at Kabhokweni hospital as well as in Masoyi and Hazyview police stations. “GRIP provides confidential, sensitive and comprehensive trauma counselling along with practical assistance and support to help rape, sexual assault and domestic violence survivors successfully obtain necessary health services, prosecute offenders and recover physically, emotionally and mentally with immediate, on-location services in police stations, courts and hospitals, and via

extensive in-home post-assault services" (SANGONet 2014);

- The Masiphephe project informs stakeholders about issues related to GBV;
- The TCC situated in Kabhokweni provided support for victims who often do not have the resources to go to different places for treatment. Additionally, the full 28-day course of Post Exposure Prophylaxis (PEP) medication is provided to victims on the first visit to minimise medication defaulting by victims who do not have transport fare to go back to the TCC to fetch their repeat medication;
- Because of the door-to-door outreach programmes conducted by the SAPS officials, community members are given a chance to understand that police officials do not only arrest but also care for the community by sharing information on how to protect themselves against criminal activities, including GBV;
- Collaboration between the SAPS and local churches, schools, and other organisations in the sharing of GBV information; and
- Collaboration between various stakeholders through OSS.

2.3.4 Emalahleni

- TCC is seen as the biggest strength for the community of Emalahleni. Through the TCC, survivors (both children and adults) have easy access to the police, places of safety and counselling services;
- Foundation for Victims of Crime (FOVOC) offered services, such as raising the community's awareness to issues of GBV, offering counselling and shelter to survivors, victim empowerment, and skills development, while in the shelter so that victims can sustain themselves financially post the GBV experience;
- Victims are empowered by an increased conviction rate that is attributed to the justice system's improved communication with the community regarding their cases (i.e., court date postponements);
- Collaboration between the various stakeholders working on issues of GBV;
- Disciplinary actions taken by the local taxi association against taxi drivers who abused passengers;
- More organisations dealing with GBV;

- KHULISA Social Solutions, an NPO focusing on inspiring, empowering and offering of diversion programmes to offenders, vulnerable children or children/youth in conflict with the law to unleash their potential and provide skills for a positive future. Programmes offered by KHULISA are broken down into the following categories:
  - ✓ Corporate Programmes
  - ✓ Diversion Programmes
  - ✓ Employment Generation Services
  - ✓ Entrepreneurship Development
  - ✓ Early Childhood Development (ECD)
  - ✓ Offender Rehabilitation and Reintegration Programmes
  - ✓ Parenting Programmes
  - ✓ School Programmes
  - ✓ Victim Offender Mediation Programmes
  - ✓ Women and Victim Empowerment Programmes (KHULISA Social Solutions 2020).

However, it was reported that KHULISA was experiencing challenges with regards to funding and had to close some of its offices and discontinue some of the programmes it offered.

- Conducting community outreaches or *izimbizo*[18] increased the community's awareness to issues of GBV.

2.3.5 Alexandra

- Stakeholder collaboration;
- Services offered by Medico-Legal as previously discussed in depth under section 2.2;
- ADAPT working hand in hand with the police, going door to door bringing awareness to the community;

[18] *Izimbizo* is a plural form of *imbizo*, which means a gathering, or meeting that is usually called by a traditional leader.

- ADAPT is one of the first women organisations in the country to engage men as part of the solution to addressing violence against women. Male social workers offer counselling and support services to men who are perpetrators of violence against women;
- Radio programme: A good working relationship between ADAPT and the local radio station. Alex FM has enabled the organisation to educate the community about issues pertaining to human rights, GBV and the importance of utilising available counselling services;
- ADAPT has forged a good working relationship with the Department of Education and the local schools that enabled it to address issues pertaining to sexual violence and bullying in schools. Apart from facilitating training sessions and workshops for learners, educators and ground staff, the social worker and an auxiliary social worker from ADAPT offered counselling and support services to learners in schools;
- ADAPT assists schools to operationalise safety policies/frameworks to enable management of unacceptable behaviour in schools;
- Six accredited facilitators, moderators, and assessors from ADAPT offer training whenever a need arises;
- Strategic location of ADAPT comprehensive counselling and support services for victims of GBV in the community for easy access. Counselling and support services offered at the Victim Empowerment Centres based at the Sandringham Police Station and the Alexandra Police Station will soon be extended to the Bramley Police Station;
- An arts and healing project by ADAPT. Various art forms used to help clients heal from their experiences.

2.3.6 Diepkloof

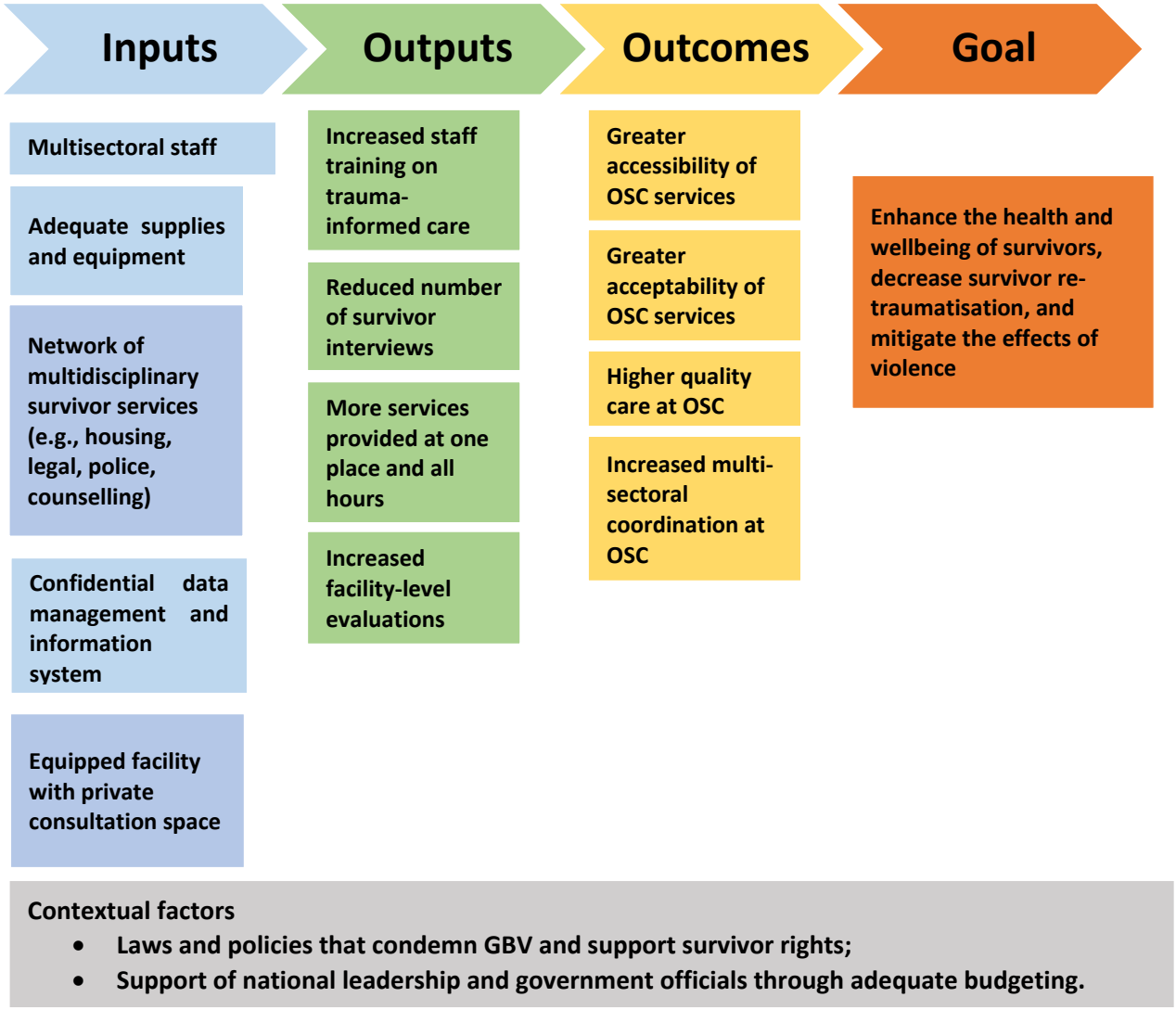
- Commitment from community members who assist and make sure that cases are reported and that survivors are supported after reporting;
- Campaigns and marches taking place, radio programmes that focus on issues of GBV where listeners are encouraged to call in to participate in the conversation;
- Effective response to GBV incidents by FCS at Protea Glen Police station;

- Integrated and holistic support services (i.e., medico-legal and psychosocial) offered at the Naledi TCC at Baragwanath Hospital. In addition, social workers based at the NTCC ensure that rape victims get the assistance they require within 72 hours of being victimised;
- People Opposing Woman Abuse (POWA) NGO situated in the NTCC premises assists with effective management of cases;
- Effective referrals by NPOs such as Childline, Families South Africa (FAMSA) and Child Welfare;
- Collaboration of stakeholders with different types of expertise;
- The Masiphephe project brings together and empowers stakeholders. The collaboration of stakeholders, enabled by the Masiphephe Network, has improved the referral process;
- Facilitation of stakeholder collaboration by Sonke Gender Justice;
- Men's training programme in Meadowlands Sport Clubs in partnership with Jozi FM where teenage boys are taught gender confidence, communication skills and empathy. The programme also focuses on teaching the community about GBV using the medium of radio; and
- Awareness of the Masiphephe project by the community.

A closer analysis of the strengths listed above per site revealed that two strengths were identified at all projects sites, namely, collaboration and the one-stop centre (OSC) model of the TCC or medico-legal in the case of Alexandra.

Discussions throughout this report show that TCC, as an OSC, is considered one of the most effective strategies as it encourages collaboration and coordination of efforts by various stakeholders to respond to and prevent GBV, more especially rape and sexual offences. Olson et al (2019, p. 33) explain that the OSC model is designed to "provide effective, multidisciplinary, coordinated and survivor-centred care to survivors". They add that the OSC was created to respond to various issues identified by survivors when seeking support and services from non-integrated organisations (i.e., healthcare, the police, and legal systems) (Olson et al 2019, p. 2).

Figure 5: OSC theory of change



Source: Olson, Carcía-Moreno & Colombini (2019, p. 3)

The non-integrated model of dealing with GBV often puts victims in a position where they need to retell their traumatic stories every time they encounter a different service provider, which perpetuates secondary victimisation. As a result, the focus of the OSC model is meant to increase "accessibility, acceptability, quality and multisectoral coordination of care in order to reach the ultimate goal of reducing survivor retraumatisation when seeking care" (Olson et al 2019, p. 2). The strength of the TCC, as an OSC, is summarised in the verbatim response from a Statutory Stakeholder:

> "The strength; I am happy about the initiative of the Thuthuzela Care Centre because one of the strengths that we have is that victims are never sent from pillar to post anymore. Once they are here, they become our baby for six months."

Figure 5 in the previous page shows the theory of change of the OSC by Olson et al (2019) which highlights the goal and the importance of a one-stop centre for survivors of GBV. A theory of change explains how a programme contributes to the desired results. This theory of change of an OSC can, thus, be used as a monitoring and evaluation tool by the NPA to, firstly, identify gaps at the TCCs and, secondly, to evaluate whether TCCs in their current state are effectively achieving their objectives.

2.4 INFORMATION SHARED BY LOCAL NETWORKS ON GBV

When participants were asked which channels were used to disseminate information on issues related to GBV as well as support services, various mediums, such as the media (more especially radio), pamphlets, community programmes, dialogues and *izimbizo*, awareness campaigns in the community, schools, churches, hospitals, and clinics, were identified. What was unique in KwaNdengezi was an art and culture organisation named Isimilo Production that focused on the spreading of GBV messages using drama, poetry, and Zulu dance. The primary goal of the organisation is to remove children from the streets and keep them busy through involvement in recreational activities. This programme is rooted in the African oral traditional paradigm of storytelling and thus can be an effective tool used to spread GBV awareness through a mode that is both treasured and understood by people in the community.

Considering that community members did not attend GBV programmes and the information on GBV was not effectively cascaded, it is surprising that none of the research participants mentioned the use of social media platforms to spread information to the community. Social media is one of the most effective communication tools as it can be used to raise awareness on diverse and social issues. Social media operates at high speeds and thus a message can be spread to a large audience in a short space of time. According to O'Dea (2020), approximately 22 million people in South Africa own a smartphone and it is predicted that the number will rise to more than five million by the year 2023. Consequently, since a smartphone allows one to perform other digital activities (i.e., surfing the internet; logging on to social media) beyond

just making calls, this technology may increase access of GBV information by the community. Moreover, social media has various positive societal impacts such as bringing people together, creating an inclusive space for different voices and promoting activism.

The following topics were listed by the participants when they were asked about the type of information shared with the community on GBV:

- Information on what causes GBV, how to report and services available to victims and their families;
- Psychosocial and health issues and the relevant service providers offering these services;
- Teaching of school children about their rights and the processes to follow should they feel that they are being abused;
- Drug awareness;
- Education on HIV/AIDS and its connection to GBV; and
- Programmes on parenting.

Participants in KwaNdengezi reported that sociocultural norms dictate what type of information is considered acceptable to be shared within the greater social context and with whom it should be shared.

CHAPTER 3

3.1 ACCESS TO JUSTICE

Access to justice is defined as "the ability of people to seek and obtain a remedy through formal or informal institutions of justice, and in conformity with human rights standards" (Cissé, Muller, Thomas & Wang 2013, para. 4). This theme focuses on participants' opinions on what justice for survivors of GBV means and whether justice is attained only through the formal CJS or if there are other ways of attaining justice. Various challenges with the CJ are also explored. The theme is sub-divided into the following sub-themes: reporting and response; good outcome for a GBV case; and challenges with the justice system

3.1.1 Reporting and response

The first step to accessing justice is disclosing or reporting the incident. Participants across all sites reported that victims report incidents of GBV to various avenues, such as clinics, hospitals, churches and schools, but the police station is, in most cases, the first point of contact for reporting GBV. They emphasised that survivors generally report GBV to individuals they trust, such as child victims who mainly report to individuals such as teachers, close family members or neighbours. On the other hand, the participants' replies about trust contradicted their view about the police as the majority reported that they did not trust police officials (see section 3.1.1.2). When asked for reasons why people did not report incidents of GBV, five main reasons were shared across all project sites.

3.1.1.1 Secondary victimisation

All sites revealed that one of the primary reasons that individuals do not report GBV cases, especially to the police, is secondary victimisation. Re-victimisation takes place through victim blaming or disbelief, insensitivity towards the victim and insensitivity when dealing with members of vulnerable groups such as children, the elderly, persons with disabilities and members of the LGBTQIA+ community. This includes a lack of privacy and confidentiality when statements to the police are taken in the CSC. The latter is a violation of the first victim's right (i.e., to be treated with fairness, respect, dignity and assisted in private) as highlighted in the Victims' Charter discussed in Chapter 1. It highlights a further issue regarding the lack

of or limited use of victim friendly facilities (VFF) at police stations. This was reported by participants at all of the sites except for Alexandra:

> "Our CSC, you can go to any CSC, they are mostly open you know? And some people are afraid, one will come, you know, people come to the door and then go back. If you can follow that person and ask 'Why did you go back home, what's wrong?' And they will tell you that 'No man, there is people here, I cannot just come and say …' because, even with us police officials, I will be standing there and there are people and I will shout 'Can I help you? Huh! I can't hear you!' So those are the things. Ja, we need a victim friendly facility where people will be able to, you know, to just be free and tell their story." [Statutory Stakeholder]

> "There must have been a separate office for that particular issue … because some of the police, as soon as you come and tell me about the GBV, there are other people around who are listening … this conversation is supposed to be taken in a private room and you have got a victim trauma centre there … we do have a victim friendly room." [Statutory Stakeholder]

> "And another thing, even when they get there when, even the SAPS is not victim friendly because you have to talk in the front desk." [Statutory Stakeholder]

> "Also ensure that the statement is taken in a separate room, so that the rights of the victim is considered and respected so that secondary victimisation is avoided."

> "What I can say? It is a challenge internally at the station is the issue of not having a trauma room where … when someone comes, like rape victims, someone who is abused from home, be able to [speak]. That private space is not there to interview those people, everyone just goes to CSC, yes, so that is the one thing that is the main challenge I see happening a lot here at the station, yes!" [CBO Stakeholder]

Reasons attributed to the limited use of VFFs were police officers' lack of knowledge on how to treat GBV survivors and a lack of equipment and human resources.

> "Oh, nana, they are opening at the CSC not there … this is the thing that I am trying to say … Before even they give the information, I should be able to take them to victim friendly room … but it is not done by police officers … this is why we are saying there should be more proper workshops … and more courses as well, like victim empowerment, domestic violence, and vulnerable children … more specially those three." [Statutory Stakeholder]

> "It's fully equipped but human resource wise now, 'cos previously, the most of our victim friendly facilities here in Ehlanzeni, they were operating 24 hours but now you find that they are operating during the day because we had volunteers before who were there supplied by GRIP. So, since GRIP lost some funding previously, then they had to withdraw some of their volunteers." [Statutory Stakeholder]

Research participants added that the police were not the only service providers who retraumatised survivors of GBV. In line with available data, survivors can also be retraumatised by family members, the community and other service providers dealing with response and prevention of GBV.

3.1.1.2 Lack of trust

Almost all participants, including police officials, reported that there was little to no trust between community members and the police and therefore survivors of GBV were unlikely to report their victimisation to the police. This was attributed to police officials' poor understanding of victims' needs and the impact of trauma on victims. In addition, the lack of trust between the police and community members was attributed to police corruption. Some police officers could not be trusted since they were friends with the perpetrators. Based on the report by Corruption Watch (2019), corruption in the police during the year 2019 surpassed corruption reported in other departments such as schools, health, and local government. Furthermore, the two types of police corruption mostly reported are abuse of power reported in 35.7% of cases and bribery amounting to 30.6% of all corruption cases (Corruption Watch 2019).

3.1.1.3 Socioeconomic issues

In line with existing literature on the topic, this study revealed that women who were victims of GBV, specifically DV, did not report the crime due to being financially dependent on their abusers. They felt afraid of losing their homes, their ability to pay bills – including food, clothing, school fees and other daily expenses – or feared not being able to survive without financial support, being homeless, or losing their children. According to Statistics South Africa (Stats SA 2020), the number of unemployed people in South Africa over the 10-year period between quarter one (Q1) of 2010 and Q1 of 2020 increased from 64% (n=4.6 million) to 71.7% (n=7.1 million). Additionally, the official Q1 2020 unemployment rate is 30.1% (n=7.1 million) which brings the overall number of unemployed people in South Africa during Q2 of 2020 to 10.8 million. The expanded unemployment rate for Q2 of 2020 is 37.7% which is also an increase of 1% when Q2 of 2020 is compared to Q4 of 2019 (Stats SA 2020).

Table 4: The expanded definition of unemployment

Expanded definition of unemployment includes the following:	
- Official unemployment (searched for work & available)	7.1M
- Available to work but are/or	
• Discouraged work-seekers	2.9M
• Have other reasons for not searching	0.8M

Source: Stats SA (2020)

Stats SA (2020) further reported that, where gender is concerned, more women (n=32.4%) were affected by unemployment in Q2 of 2020 than their male counterparts (n=28.3%). In addition, in Q2 of 2020, black African women were the most impacted by unemployment with the rate of over 30% (Stats SA 2020). As such, the South African unemployment rate by gender explains why participants in this study stated that the great majority of women who were victims of DV did not report their abuse due to financial dependency on their violent partners.

This study revealed that economic deprivation is linked to VAW. Conversely, the changing economic status of women, who become financially independent, was a risk factor for IPV. Only one participant (a social worker in KwaZulu-Natal) reported that many professional and educated women also experience IPV, but the majority did not report it since they needed to maintain their social status. However, this is a perpetuation of a myth that only certain people

are susceptible to GBV.

3.1.1.4 Personal safety

Participants in KwaNdengezi and Emalahleni reported that some victims did not report GBV because they received threats from their abusers, their families, or the community. Getting help for DV often increases feelings of fear for victims. They may fear that the abuse will get worse, that the abuser will retaliate, that they will not get the protection that they need, or that seeking help will make the situation worse. Sometimes, trying to seek help can aggravate an already violent situation. The protection of children is also high on the list of the decisions taken on whether, or how, to seek help. As three women in South Africa are killed each day by their abusive partners, the threat of further harm when leaving a relationship or seeking help outside of the family, is real.

3.1.1.5 Distance of the police station from the community

In KwaNdengezi and Mbombela, most of the rural communities were discouraged from reporting cases of GBV because their local police stations were too far away.

> "Some communities don't have police stations, so they have to travel very far to access services. If police stations can have sub stations in areas to cover the areas that do not have access to police stations. Some people in Pinetown don't access services 'cos it's too far." [CBO Stakeholder]

> "What we need the most or what the community needs the most, the police are far, they are at Ndengezi, and we are at Zwelibovu. How can you go to Ndengezi where you need to take two taxis to get there? Let's say you are in an emergency situation, say you were raped or running away from someone who raped you, or you are being stabbed or someone wants to kill you or whatever, it is very far. Sometimes they transfer you to Mbumbulu because sometimes they say Zwelibovu is under Mbumbulu Police Station, so what they can do to help us is to build those small police satellites so that we know that, if one is in an emergency situation, they can go there then, only after that, the police can report to the big station. That would make some of the things change in our community." [CBO Stakeholder]

Harmful cultural practices are discussed in more detail later in section 4.1.

3.2 GOOD OUTCOME OR JUSTICE IN A GBV CASE

When participants were asked what, in their opinion, was a good outcome of justice for survivors of GBV, they explained that justice means different things to different people and that justice can be attained either through the formal justice system or through other ways such as counselling. The central message spread across all six sites was that justice was attained in a GBV case when the survivor received holistic and integrated support services, which are victim centred.

> "It's a holistic approach. If the victim feels that all steps have been followed and is treated fairly, then the victim feels like their trust is regained." [Statutory Stakeholder]

> "I would say, if a person has been raped, for example, she/he must get healing and the person who has raped must get the deserved sentence. The victim must further receive support maybe in a form of counselling from social workers or psychologists."

> "Good healing is found through counselling. They go to court only and their case is resolved in court. Some of them don't heal through the court process, they just become happy because their case is resolved but counselling is very important."

The need for a protection order (PO) was reported in only one site, Alexandra. This may be related to the community's lack of understanding of the purpose of a PO order and the processes followed to attain it.

The schematic representation on the next page depicts the participants' views of a good outcome, justice for a GBV case or what victims sought when they reported.

Figure 6: Justice in a GBV case

When participants were asked about the consequences of not attaining justice for GBV survivors, they reported that survivors were negatively impacted psychologically and mentally (i.e., post-traumatic stress disorder [PTSD], loss of hope, loss of trust in the system, inability to heal emotionally) to a point where some committed suicide (also refer to section 1.2.3). Study participants explained that, if the violence continued, some victims normalised the abuse while others or the community took the law into their own hands through acts such as vigilantism, also referred to as “mob justice”. Mob justice takes place when the community attacks a person suspected of a criminal act with stones, clubs, machetes and other weapons. Mob justice was often caused by failures in the justice system such as corruption, poor laws and waiting for justice.

3.2.1 Challenges of the justice system

The next two questions on access to justice were centred on the challenges experienced with the justice system and what can be done to improve this. In their responses, participants focused exclusively on the police and the courts. Some of the challenges raised by participants under this theme were also raised in the previous theme (see section 3.1) and were discussed above. As a result, to avoid repetition, this section focuses on issues such as systemic racism, poor police visibility, cases being struck off the court roll, cases taking too long to finalise,

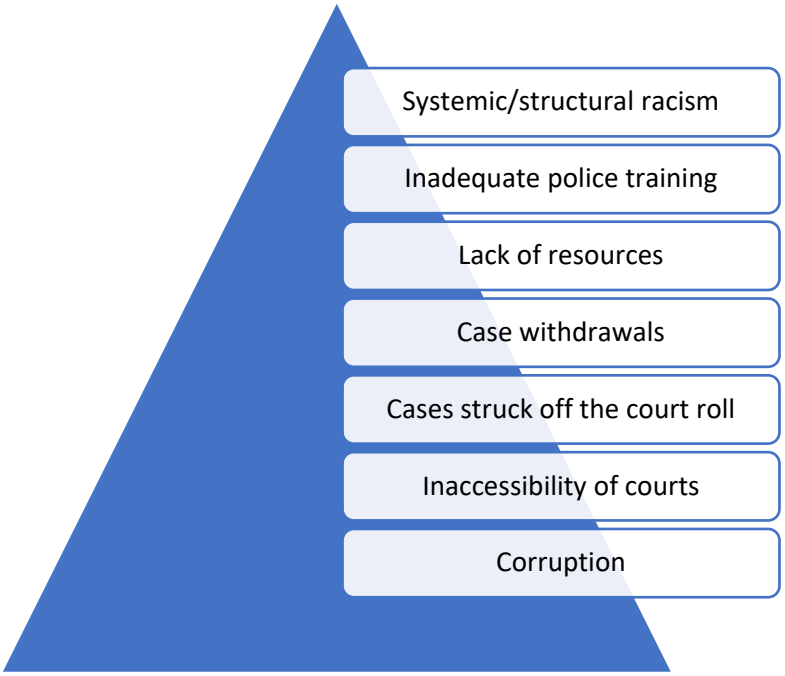
language barriers, and inaccessibility of courts as shown in Figure 7 below.

3.2.1.1 Systemic racism

A participant in KwaNdengezi pointed out that one of the main problems with the justice system was systemic racism, which was said to be linked to the delivery of poor quality services, mostly in rural and township communities, where the great majority of inhabitants are black people. Johnson (cited by Yancey-Bragg 2020, para. 4), defines systemic, institutional, or structural racism as "systems and structures that have procedures or processes that disadvantage [people of colour or Africans]." The stakeholder, who raised the issue of structural racism in KwaNdengezi, explained that the justice system that served the rich who are mainly white (living in urban areas) was not the same as the one that served the poor who lived in rural and peri-urban areas. He postulated that justice served the rich and not the poor and thus structural racism or class issues contributed to the substandard services provided to poor communities by CJS role-players.

> "But, in situations where you are dealing with poor quality services especially in rural areas and townships, because in South Africa the class issue is always there. Justice system that serves the rich is not the same as the justice system that's serving us here. Health services, there was a debate here in the morning about a couple that was attacked and killed and there was a reward of R100 000 for anyone who can come forth with information leading to the arrest and successful prosecution. But how many people die here, but we never hear of any reward being put forward. Those structural issues will always be a hindrance to once accessing justice here in South Africa." [Statutory Stakeholder]

Figure 7: Challenges with the justice system in the community



Regarding structural racism, two participants (one from KwaNdengezi and another from Diepkloof), representing a CBO and an NPO respectively, argued that some of the problems experienced with the justice system in their communities could be attributed to **language as a barrier**. They explained that, as much as police officers were blamed for not taking statements properly, the fact that they are expected to take statements in English and not their first language or mother tongue exacerbated the problem. Moreover, it was also not easy for survivors to tell their stories or for witnesses to testify in court in a "foreign language".

> "The number one challenge is language because the reports must be written in English and most of the people writing the report do not have English as their first language." [NPO Stakeholder]

> "The Pinetown Court, I'm not happy, I'm not too sure who's there as SPP at the moment but, you see, the majority, which is being accommodated to it, are the Africans so you cannot have a Senior Public Prosecutor [who is Indian] who will not understand isiZulu per se because you find out that

> maybe some are not fortunate enough to be educated, you know some can't speak English …." [CBO Stakeholder]

The second verbatim response raises a concern regarding the utilisation of interpreters in court. Court interpreters play a critical role in the administration of justice by ensuring that those who do not understand the language of the court, which is English, are able to fully participate in the court processes. Lee (2009) defines a court interpreter as a professional who is engaged in court proceedings involving witnesses and defendants from different cultural and linguistic backgrounds. The interpreter, therefore, interprets the court proceedings by searching for linguistic and cultural equivalents to make sure that participants from diverse linguistic and cultural backgrounds receive the original message conveyed by the speaker (Lebese 2013).

3.2.1.2 Cases struck off the court roll

Participants in KwaNdengezi and Mbombela mentioned the many GBV cases which were purported to be struck off the court roll as one of the challenges the community experienced with the justice system. When queried on why cases were struck off the roll, participants pointed out poor investigations and the lack of evidence as two of the primary reasons. Further mentioned as a point of contention with the court at the same sites was the number of **cases being withdrawn by the court** for the same reasons as cited above.

> "You know, they used to strike off cases just like that. I understand that their roll is long. They can't even cope with it. But striking off a case, you know, to investigate a case is long but to finalise is something else. So you find that you have to take back the docket on the roll. It's a problem! Tracing of witnesses. Some are no longer staying there, their contact numbers are not working, the perpetrator himself ducks and dives when we are looking for them. Because we have to issue a J175, that's a summons, because we cannot re-arrest them. You have to give them J175 so they can appear in court again. So that is a problem that we are facing right now." [Statutory Stakeholder]

Poor communication by Investigating Officers (IO) was further mentioned as a challenge that caused frustration to victims as they were not regularly informed about the status of their

cases. Refer to the Victims' Charter discussed under the literature review (section 1.2.4).

> "He will keep quiet and not tell the victim that you are supposed to appear in court on this and that date. And then, when the victim asks about his/her case, then he/she is told that the case was struck off the court roll because you didn't show up."

Contrary to the challenge of finalising cases in Mbombela and KwaMashu, the participants maintained that the introduction of the sexual offences courts was, to a certain extent, speeding up the process of finalising sexual offence cases:

> "They take too long to finalise; they have a system but nowadays it's much better than previously." [Statutory Stakeholder]

> "We also have two sexual offences court [in Ntuzuma] which are well equipped, they have all the resources. The sexual offences courts started in 2013." [Statutory Stakeholder]

The above is concomitant with the findings of the ICOP baseline study that revealed that, in the five sexual offences courts that were part of the study, most of the cases (65.2%) heard in these courts were finalised in 0–9 months and a further 23.5% of cases were finalised within 18 months. Nonetheless, the ICOP study also highlighted some challenges experienced by the sexual offences court one of which was the "inherent interdependence in the criminal justice system that often causes serious delays in the finalization of cases" (Heath et al 2018, p. 10). This was also found in the current study and was explained by one of the participants, in KwaMashu, as follows:

> "Yes, even if they do, but remember that we are still depending on the very same people who work in the other courts to work in the sexual offences courts." [NPO Stakeholder]

The final challenge was the inaccessibility of courts by community members. Participants said that court buildings and the system are perceived as being cold and unwelcoming. In addition, it was reported in KwaMashu that the local court was inaccessible to persons with disabilities as it did not have a wheelchair ramp. The inaccessibility of the courts also led to the non-attendance of community awareness campaigns by court officials. It was for this reason that

participants felt that most members of the community do not understand how the CJ functions as the information is not cascaded.

Participants in Alexandra mentioned issues with the Domestic Violence Act (DVA) (DoJ & CD 1998). Fortunately, in March 2020, the Department of Justice and Correctional Services (DJCS) called for submissions on the Domestic Violence Amendment Draft Bill 2020 in order to amend the DVA 1998 in the following ways:

- Further regulation of certain definitions;
- Additional facilitation for obtaining of POs against DV;
- Introduction of obligations on relevant officials in the DSD and the DoH to provide certain services to victims of DV; and
- Alignment of the provisions of the DVA 1998 with the provisions of the Protection from Harassment Act 2001 (DJCS 2020).

The following organisations, together with the GHJRU, made a joint submission to the above call: Böll Foundation, MOSAIC, Lawyers for Human Rights, National Shelter Movement of South Africa, Women2Women, Cape Flats Women's Movement, Mid-Way Services, Gendered Violence and Urban Transformation in India and South Africa Project, National Shelter Movement, Saartjie Baartman Centre for Women and Children, and Obstetrics & Gynaecology Education, UCT.

3.2.1.3 Challenges with regards to the SAPS National Instructions

With the above challenges in mind, six law enforcement officials were asked specific questions relating to the availability of national instructions that provide guidelines on how to handle the various types of GBV. These specific questions were developed during the research as issues relating to the lack of police training in dealing with GBV arose but not all police officials who were part of the study were asked these questions. Six participants answered this question and reported that national instructions were available at police stations in their respective areas:

> "We've got Domestic Violence Act Registers. They are assisting the police to know how to serve the community, what is expected of them and all those things. You've got the National Domestic Violence Act 116 of 1998; we've

got also the Sexual Offence File in which we should contain national instructions regarding sexual offences. The other one is also the National Instruction 3/10: The care and protection of children in terms of the Children's Act. And then, the very same sexual offence file, it also contains the list of probation officers, emergency numbers so that we know whom to call in a case; it depends on the nature of the incident. And then again, we've got also, is it SAPS 508? In a case where the victim of domestic violence came to the station after hours and the court was closed where they cannot be able to apply for the protection order, so you can't say 'go home and tomorrow go to court to obtain the protection order'. So that 508A, that's the one that you will complete for the victim right then. That will list the short description of what happened, where you can even go and serve it to the perpetrator on that night. The following day, you can take it to court to apply for a proper protection order. But again, you can use the very same 508 if need be for removing the victim. You also, you do that. Either you remove the victim or you arrest the perpetrator, it depends on the nature of the incident. So there are a lot of registers. Actually, some of the registers, they are supposed to be in the vehicles carried by members whenever …. Yes, they are at the station, they are part of handing over, they know whenever they knock off they must do the handing over. They will be recorded there that there are also these files which have been handed over. And again, it also contains Station Orders. A Station Order is the one that tells you about Victim Friendly Facilities. It also tells you how to assist. It tells the police officers, especially those in CSC, what are their responsibilities [are]." [Statutory Stakeholder]

Conversely, it was stated that the availability of the national instructions at the stations did not mean that all the police officials were aware of the documents:

"No, because you'll find, in certain stations, when you try to sensitise them about it, you guys are in offices and those are the people in the front who are actually dealing with the community; they have no idea what this is. When you walk into a charge office and you ask them, they get stubborn about the national instruction; they'll ask you: 'what are you talking about?'" [Statutory Stakeholder]

When participants were asked if, in their opinion, police officials could both interpret and apply the national instructions, it was consistently reported that many police officials, especially at station level, did not know to implement the national instructions:

> "They do have a piece of the national instruction. The challenge is they interpret it in their own way." [Statutory Stakeholder]

Concerning training on how to handle GBV issues, the following responses were submitted:

> "We receive FCS course. I think it's two months and then it includes victim empowerment, how to handle victims of rape and all, you know, cases that we must deal with as FCS. And what else is there? Before you do this course, we need to do the detective course which takes about three months and thereafter you can do these small ones. You cannot work at the FCS Unit without this course. As soon as you join us, we make sure that we send you to that training. Then we also have workshops that are conducted around the organisation about gender-based cases." [Statutory Stakeholder]

> "We do domestic violence training and then, eerrr, victim empowerment programmes, Child Justice Act. They are a lot. I do have a document on the system that I complete monthly that how many people did which training on the list of all the trainings at the station level. But I will check and send them to you." [Statutory Stakeholder]

> "We go to a one-week training … it tells us … how can I explain it? Shame, it explains to us how the policies work, the Acts that we use, how do you open up files, mmm, how do you interview an individual?" [Statutory Stakeholder]

When the members of the SAPS were probed on what they would like the community to change to make their work easier in relation to GBV, two main responses were provided:

- Community members should not stigmatise gender minority survivors of GBV; and
- Community members should change their negative attitude towards the police and be more understanding of investigation procedures that need to be followed.

Even though national instructions are available in police stations, some officials are either not

aware of the instructions or do not understand how to implement them. The length of training offered to officials working in special units, such as the DV unit, is of concern as it is only one week on GBV related issues.

CHAPTER 4

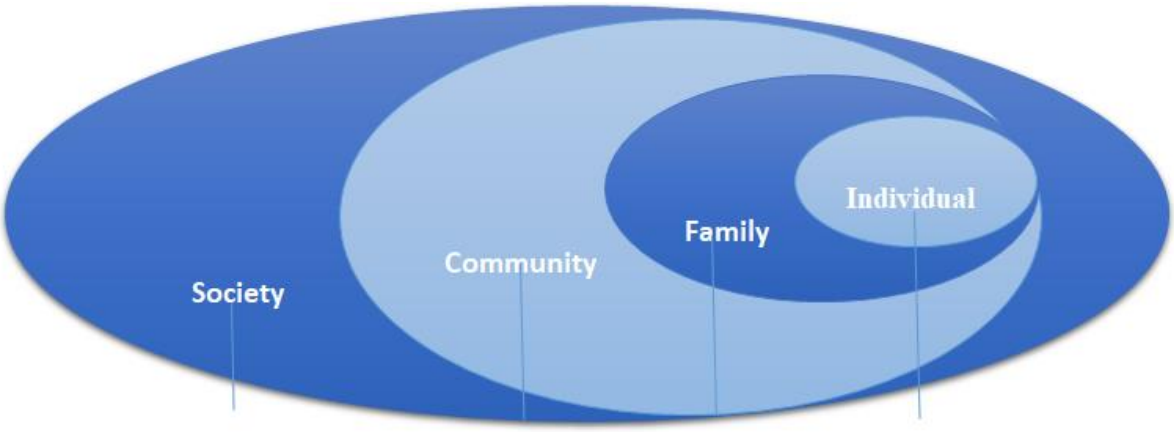
4.1 GBV RISK FACTORS

Risk factors were determined using the ecological model adapted from Heise (1998). The ecological model presents causes at the individual, family, community, and society levels. This theme is divided into the following sub-themes: causes of GBV, types of GBV committed in the community, and issues affecting vulnerable groups.

4.1.1 Causes of GBV

Researchers on the topic of GBV and criminality in general agree that no single risk factor determines the development of delinquent behaviour or is the cause of violence, but a combination of multiple risk factors are associated with criminal behaviour.

Figure 8: GBV Risk Factors



Harmful social norms	Poverty, unemployment, and lack of education, substance abuse, overpopulation, environmental design, normalisation of GBV	Financial dependency on abuser, substance abuse	Witnessing violence as a child

Source: Adapted from Heise (1998)

4.1.1.1 Individual risk factors

According to Tremblay and LeMarquand (2001), individual risk factors are made up of an individual's physical, emotional, cognitive, and social characteristics resulting from either genetics or the environment. Farrington and Welsh (2007) posit that low intelligence and attainment, and low cognitive empathy are some of the predictors for developing criminal behaviour. On an individual level, the following were found in this research to be risk factors for GBV: witnessing conflict between parents during childhood, being abused as a child, having an absent father, and substance abuse.

> "You would find that a child that comes from a home where s/he always sees a mother beating the father or a father beating the mother, that child, that child grows up with that thing of knowing that a human being is supposed to be beaten up. So, when you have made a mistake, there's no conversation, you just slap, or take a stick, a belt or whatever and beat up the person relating to however the events happen at home." [Statutory Stakeholder]

> "… as well as parents in some communities; both the mother and father would consume alcohol, then they would fight in front of their children."

> "They are all disturbed because these kids witness a lot of things that happen at home. I think even with the parents fighting, with the fathers drinking, the mothers drinking … You understand?"

One of the ECD stakeholders reported that a child once arrived at one of their day care centres with a knife.

> "… every morning, when we arrive, we do inspection, checking children's bags if there is nothing or what are they carrying, so for him/her, the teacher that was in charge of the inspection that day was still busy with something, so s/he entered. So when s/he has entered with his bag unchecked and put it down. They were playing the free play from inside and the child just took

> out the okapi[19] [knife]. S/he knows it as something to play with because s/he usually sees this thing done at home.... the children were screaming, 'so and so is carrying a knife!' We ran and we saw the knife has rusted. 'Where did you get that knife?' 'I took it at home.' … we ask: 'What?' 'Where have you seen what you are doing?' He responded, 'my uncle' ...." [Statutory Stakeholder]

The excerpts above confirm the central message of the Social Learning Theory (SLT) by Albert Bandura (1971) that criminal behaviour, just like any other behaviour, can be learnt through observing and imitating others. According to the SLT, learning is a cognitive process which takes place in a social context and occurs in three ways, namely, observation, imitation, and modelling (Bandura 1971). Additionally, learning also takes place through reward and punishment or a process called "vicarious reinforcement" or "vicarious punishment" (Bandura 1971). This means that, if a child observes criminal behaviour being rewarded instead of being punished, then the likelihood of him/her learning the criminal behaviour is increased since it is perceived as bearing positive rewards.

4.1.1.2 Family risk factors

Research on the causes of childhood offending as well as adult criminality often attributes antisocial behaviour to family influences (Derzon 2010). DeLisi (2005) explains that dysfunctional families defined by parental conflict and separation or divorce; poor parenting skills; inconsistent or harsh discipline; inadequate parental control; lack of supervision and monitoring; poor or disruptive attachments with the child; low family income; and weak bonds among family members are predictors of a pathway to criminality. Family is the first institution of socialisation therefore the failure to form positive domestic relationships or develop positive attitudes from interactions with family members, the higher the likelihood of following a criminal pathway. The afore-mentioned family risk factors are emphasised in the verbatim responses below.

> "I'm [not] sure whether the single parenting thing is also the contributing factor eh …. Joh! Single mothers are a lot, a lot here of single mothers and

[19] The okapi is a lock back or slip joint knife.

they also want to have life as well ….” [Statutory Stakeholder]

“… the parents drink and they abuse children in the house, and others. Even if there’s no abuse, some parents don’t have time for children anymore, to sit down with a child and tell her the truth, they just say no she will see for herself, she doesn’t listen ….”

“Sometimes a child goes absent [from school] because, eh, at home, the mother and father had had a fight”. [Statutory Stakeholder]

“Financial matters. Males, when it comes to supporting and preserving the relationship, and they don’t want to play the part when it comes to taking the responsibility [when it comes to their children] and ends up the mother being affected and results in violence ….”

A closer look at the data, particularly the fourth verbatim response highlights parental disagreements about child rearing or discipline as a familial risk factor that may cause a child to develop violent behaviour.

4.1.1.3 Community risk factors

Substance abuse, specifically the abuse of alcohol, was highlighted at all sites as one of the biggest causes of GBV in the community. It was further highlighted that there were too many taverns in the communities and that most of tavern owners did not abide by the Liquor Act, 2003 (No. 53 of 2003) (hereinafter referred to as the Liquor Act), as well as the Provincial Liquor Acts which regulate the operations of taverns. The Liquor Act contraventions by taverns or *shebeens* included operating illegally without a licence, not obeying operating hours and selling alcohol to underage children. Participants were particularly concerned about the many taverns in their communities which meant an increase in the amount of alcohol at the disposal of community members, as well as children. Consonant to previous research studies on GBV, participants in this study held the opinion that there was a strong positive association between alcohol and IPV. As a result, the increased number of taverns in communities contributes to the abuse of alcohol which, in turn, caused DV, particularly IPV, and other types of GBV, such as rape.

“My opinion, when coming to taverns, I can say, you know, according to the

Liquor Act, if you are a tavern owner, you've got hours that you need to operate. Okay, around here, we are trying to police that. I am more involved in that. We do go around, during our operations, whenever we've got operations, visiting liquor outlets would be part of the activities. Visiting illegal liquor outlets, which are operating without licences are part of the activities and operation. We've confiscated a lot of liquor. Ja, and if a person might operate until the time when they were supposed to have been closed, then they will be fined. At the end of the day, if the person continues, it depends whether they comply as time goes on. But, if they may give us more problems, at the end of the day, we will be forced to write a letter attaching evidence and maybe sending it through to the Liquor Board. And they can lose their licences. [Participant 2 interrupts: 'Which is seldom though']. But, at the end of the day, the patrons, they need to take the responsibility. And again, on that, we still need much of the cooperation of the liquor outlet owners and to know when they're supposed to say no to a person when they want to buy liquor. Because, according to the Liquor Act, if you can see that the person is drunk, you don't have to continue selling to that person. That's also one thing we still need the liquor outlet owners to assist us with. It's not only about them making money, because … if a person is drunk, doesn't know her name or his name, what is going to happen? That's where the abuse starts and they might only realise in the morning that I have been raped. You can't even point who raped you." [Statutory Stakeholders]

"… but what makes us see it is the usage of alcohol. Taverns are all over and they are uncontrollable …."

"With gender-based violence, it's what happens in the homes after they have drunk alcohol. You find a lot of noise, they start fighting."

Another cause of GBV was the abuse of other substances such as marijuana, woonga or *nyaope.*[20] The KwaZulu-Natal sites described a concoction called *incika* which was reported

[20] *Nyaope*, a popular recreational street drug in South Africa, is a mixture of methamphetamine or heroin, marijuana, antiretroviral drugs, especially efavirenz, and other materials such as rat poison and detergent powder.

to be abused mainly by school children or the youth. *Incika* is a mixture of Sparletta or Sprite soft drink with a cough syrup, specifically Codeine.[21] Other substances that were abused, mainly in KwaMashu and KwaNdengezi, were antidepressants such as Xanax.[22] Holland (2021) explains that people who take Xanax for recreational purposes experience a sedated or calm feeling.

> "… Woonga, although they now mix it with powder. I don't know that powder, even people who are working smoke that powder. I've seen it a lot, and then it's *incika*, they mix drink with a cough mixture and drink it and they get drugged." [CBO Stakeholder]

> "They use Sparletta Sparberry flavour. Once you see kids as a group carrying a drink, you must know they are drinking that drug, and because [they saw] artists drink that, so that it keeps them active. Then there's Xanax, doctors know, it's the medication for depression." [CBO Stakeholder]

> "I also don't know, I was still trying to find that out, but Xanax is very much prevalent in all the townships. You can find it at KwaMashu, Ntuzuma, everywhere, and in schools, especially primary. Every kid uses it, the kids that climb on top of the train while it's moving are smoking that and *incika* because it makes them feel big and powerful. One primary school principal called me to tell me how worried she was about the kids because the school is next to a forest so the kids will go there to have sex, and she was saying she is very worried because, as they are having sex, they don't even know each other's [HIV] statuses and condoms are not distributed in primary schools but only in high schools where government sees that kids are starting to grow. But these young kids grow with diseases, raping starts in primary but it is not reported and the teachers are not well educated as to how to handle such cases." [CBO Stakeholder]

Xanax is a drug which cannot be dispensed over the counter without a prescription from a

[21] The following are some of the side effects of codeine: drowsiness, dizziness, light-headedness, nausea, shortness of breath, stomach pain, sweating (Cunha 2020).

[22] Xanax is used to treat panic and anxiety disorders.

doctor. Masuku (2019) reveals that the drug is available from pharmacies at R1 per tablet and it is being sold on the streets for R7. Patel, a pharmacist, reported to Masuku (2019) that he suspects that drug dealers obtain prescriptions illegally from medical doctors to buy the drug which they sell on the streets to school children at an inflated price.

One of the stakeholders from KwaZulu-Natal revealed that children in the community start abusing substances from a very young age, during their primary school years. Substance abuse leads children to engage in risky behaviours, such as train surfing and having unprotected sex. In addition, this participant highlighted the association between being high on drugs and contracting sexually transmitted infections (STIs) and HIV/AIDS as described in the literature. Due to community risk factors, such as the abuse of substances, children start committing GBV, such as rape, at a very young age but teachers are not trained to handle issues of GBV among school learners.

Surprisingly, poverty was highlighted in only one site, KwaNdengezi, as a cause of GBV. This means that community members understand that poverty alone is not a risk factor for developing criminal behaviour since there are many poor people who are law-abiding citizens. The high levels of unemployment were reported at all six sites as a source of heightened stress, which leads to GBV. Participants from Emalahleni and KwaNdengezi expressed the problem of parent mortality which made orphans vulnerable to abuse. A connection was made between parent mortality and the grooming and sexual abuse of young girls by older men, such as taxi drivers (see section 4.1.1.4 below). The normalisation of resolving issues through violence as a community risk factor was reported in Alexandra, KwaMashu and KwaNdengezi.

The issue of spatial injustice (i.e., lack of proper infrastructure) as a factor contributing towards the high levels of GBV in the community was reported only in KwaMashu. Spatial injustice involves the unfair and unequal distribution of socially valued resources and opportunities to use them.

> "South Africa's particular spatial and socio-economic characteristics and the country's history of forced segregation have resulted in a distinct relationship between crime and the physical environment. Spatial patterns and the form and structure of South African cities and towns are the result of planning principles and approaches that were largely influenced by the

> country's apartheid ideology. The poorest communities are, for the most part, located on the urban periphery, which means that the residents have to travel long distances to and from their places of employment as well as commercial, social, recreational, healthcare and other facilities. These neighbourhoods often lack adequate infrastructure (electricity, water, sanitation, etc.), facilities and amenities (including recreational facilities such as community halls and sports facilities), as well as safe public spaces such as parks" (Kruger 2020, para. 5).

In KwaMashu, the lack of recreational facilities and schools in the community meant that children often meandered aimlessly in the streets and thus ended up engaging in destructive behaviours such as abusing alcohol and other substances.

> "… there are no proper sports grounds in the community for kids to play and that has also contributed a lot." [CBO Stakeholder]

> "If you compare a school in KwaMashu with that of Phoenix, you will find that there are no facilities in KwaMashu and you would find them in Phoenix. Although, if you also compared Phoenix to Umhlanga, you also find that the standard is higher, as a result, some learners went to study in Phoenix in Indian and Coloured Schools trying to find a better education that was different from the one they received in KwaMashu. We reported this issue to the department of education that we don't like seeing our schools dying like this and this leads to many kids engaging in drugs." [CBO Stakeholder]

In Alexandra, the issue of overpopulation was mentioned as one of the risk factors mainly because services did not increase with the growth in population therefore many victims of GBV did not receive the necessary support and care they required. As Alexandra is not regarded as a permanent residential area, many people, especially those who are from other places out of the province, use it as a point of entry while searching for either work or a place to stay. When this is achieved, they leave the township. From a criminological point of view, this risk factor can be best explained through the social disorganisation theory by Shaw and McKay (1942 cited in Coleman & Norris 2000). This theory hypothesises that poverty, ethnic heterogeneity, and residential mobility lead to social disorganisation which, in turn, affects

informal social control of crime and thus increases the criminal subculture. Informal social controls are reactions by a group that enforce conformity to norms and laws that play a role in crime prevention (i.e., intervention by eyewitnesses, community patrollers, etc.). The premise of the theory is that, in communities where members do not share the same opinion of what is considered lawful or unlawful, informal social controls of crime are weakened. As a result, an absence of stable or common standards and a breakdown in community institutions result in the failure of the effective socialisation of children (Shaw & McKay cited in Coleman & Norris 2000). Likewise, residential mobility or a rapidly changing population increases community members' anonymity which makes it difficult for community members to discern criminals living among them. The issue of residential mobility was also highlighted as a risk factor in KwaMashu especially where the hostel and informal settlements were concerned. Refer to the detailed discussions of hostels in section 2.1.2.6.

4.1.1.4 Social risk factors

In this study and in line with other studies on the topic, was that GBV problems in communities reflect broader societal issues. All sites acknowledged that patriarchy, where men hold the power and women and children are viewed as subordinates, was one of the biggest causes of GBV. Harmful sociocultural norms play a significant role in the cause and perpetuation of GBV. Research participants explained that there are beliefs in the African tradition which are passed on to women by their elders when they are being prepared for or advised on marriage such as "*Lebitla la mosadi ke bogadi*" ("A woman can only leave her marriage in a coffin") and "*Monna ke tlhogo ya lapa*" ("A man is the head of the family"). Such beliefs encourage the abuse of married women and make it difficult for them to seek help from either their families or the CJS. Those who seek help from family are often pressured to stay "for the sake of the children", to "work it out", not to bring "shame to the family by divorcing", or to be "more understanding of the abuser". These pressures can make it very difficult to seek help to prevent further violence. Furthermore, sometimes victims report DV to the police, the courts, social workers or family and friends but do not receive the assistance that they need. For example, reporting to the police and being told that there is nothing they can do because it is "a family matter".

There are also traditional beliefs that define what it is that makes a man and these are often centred on the hegemonic form of masculinity. Hegemony implies power and dominance. Therefore, hegemonic masculinity is defined as a gender socialisation that perpetuates

dominance by men over women or other gender identities which are purported to be feminine (i.e., gay). Ratele (2016) explains that hegemonic masculinity helps us understand gender power, the justification of the subordination of women to men and the multiplicity of masculinities where some forms of masculinities are considered dominant over others. Even though hegemonic masculinity does not necessarily cause violence, traditional masculine behaviours or toxic masculinities can drive criminal activities, such as sexual abuse or risky behaviours that include engaging in unprotected sex with multiple partners (Langa 2020). Toxic masculinity refers to harmful cultural norms, which perpetuate harm to the society. Examples of such harmful cultural norms are the belief that a man is the head of the family, or that a wife must submit to her husband. Ratele (2016) adds that "… limited models of masculinity and the prevalent form of manhood supports violence, control of women, [and] the marginalisation of sexually and gender queer people..." (p. 9).

> "It means you're a leader, you give instructions, if instructions are not adhered to you have to use any means to make a person comply."

Over and above the negative effect toxic masculinities or harmful sociocultural norms have on women, these norms can be harmful to men as well. Social norms, such as "a man does not cry", "a man is strong" or "a man must be brave" result in cisgender heterosexual men hesitating to report GBV as they fear being stigmatised as not being a "real man" based on the hegemony of masculinity. The same is experienced by homosexual men who are often raped based on the hegemony of masculinity that they are being "corrected". They further experience re-victimisation by being scolded for not being "man enough", when they report victimisation.

In summary, the following were the most common risk factors shared by all sites:

- Abuse of drugs and alcohol;
- High levels of unemployment; and
- Harmful sociocultural norms.

4.2 TYPES OF GBV

4.2.1 Domestic Violence (DV)

All six sites unanimously reported that the most prevalent type of GBV experienced in the communities was DV. Moreover, when participants were asked which group of people was mainly victimised, all sites agreed that women and children were more at risk. This agrees with both the SAPS statistics as well as previous studies done on the topic as discussed in the literature review. In the same way, when participants were asked which group of people were more often perpetrators of GBV, they expressed that men were more likely to commit GBV than women. Nonetheless, some participants also cautioned that they did not imply that men could never be victims of GBV or that women did not commit GBV.

> "We don't seem to have an honest and frank discussion about the causes, the root causes, of gender-based violence. Instead … people may feel as if you are trying to discriminate against one party but you find that men are abused, men are abused emotionally and I believe that everyone is capable of murder; you just need the right set of circumstances to push you over the edge." [Statutory Stakeholder]

The main types of DV reported by most participants was **IPV** in the form of physical, sexual, emotional, or financial abuse perpetrated mainly by men on woman. It was additionally reported that physical violence also often took place between members of the family other than intimate partners. The over consumption of alcohol was shared as a contributing factor to the latter. The **abuse of children**, both physically and sexually, within a domestic setting was reported in all project sites. Male members of the family, such as fathers, stepfathers, brothers, and uncles, for example, were said to be responsible for the sexual abuse or incest of mostly girl children. The fact that participants across all project sites revealed that abusers were, in most cases, the only breadwinners in the family and were, therefore, often protected by not reporting GBV cases, is a concern. The family would thus rather sacrifice the child's well-being by not reporting the abuse to prevent the loss of livelihood. In cases where the perpetrator was a member of the community, he/she was asked to atone by paying "damages" to the family for the crime committed against the child. This was discussed previously in the section under interference with law enforcement by traditional leaders (see section 2.1.2.7). It is worrying that these arrangements are not victim centred and the child's

well-being is not prioritised.

> "But sometimes, in places where there are Chiefs, the people who commit crime are taken there. What do we call those courts? There is a specific name for it. We find that, at the end of the day, a person will just be fined a cow but after that nothing is happening to the victim. The victim is not given the support, NOTHING!"

Another form of child abuse in the domestic setting reported primarily in Mbombela and KwaMashu was **child neglect or maltreatment**.

> "So, if I get a child at an early age, at my 15s, 16s and then I get another child, the second one, mostly the parents chase them away. What happens, they go and rent a place and because the mother is still young and want to jive, they give their children an Allergex, you know the syrup, Allergex syrup. They give the children a syrup and the children will sleep and the mother will go to a bash for a weekend."

The above verbatim response reveals that mothers, especially teenage mothers, drug their children and leave them on their own on weekends to go partying.

4.2.2 GBV outside the domestic setting

4.2.2.1 Rape

Where GBV outside the home is concerned, the highest incidents were of rape by perpetrators who are both known and unknown to the victims, followed by physical assaults. Alcohol was reported to play a huge role in assault incidents. Moreover, spiking of girls' alcoholic drinks at parties by boys who rape them was re-counted by one participant in KwaMashu:

> "We find kids of 14/15 being raped at night … and what happens is that boys go to that ceremony [celebration/entertainment events] to sell alcohol and drugs and, if they can't find a girl, they drug her and gang rape her, that is something that is not spoken about a lot in KwaMashu but gang rape is very high and I've witnessed two of them and I called the police, I found a girl in

the morning in the forest and I could see she was gang raped." [CBO Stakeholder]

4.2.2.2 Sexual grooming

Only two sites, namely, Diepkloof and KwaNdengezi, reported the sexual grooming of schoolgirls by older men, more especially taxi drivers or scholar transport drivers.

> "So they would be sexually grooming the girl, buying them presents. … You see, the sexual grooming, especially for girls. Some of the small things that these *malomes* [uncles] would do is to sit this girl in the front seat so that she feels special. You see, those small things. And then, she's the last one to be dropped off. You see, sexual grooming is very big amongst girls and transport scholar drivers and taxi drivers." [NPO Stakeholder]

> "… if I could measure, most percentage of pregnant girls are impregnated by taxi drivers and they run away … sometimes they start by asking them out, but their purpose is not to make them their wives, their aim is to destroy the kids. In most cases, it happens to the smart kids, the ones who know what they want and then the drivers will impress them by giving them lifts to schools, bless them with nice things … yes, and only to find that, at the end, she is pregnant then the driver runs." [NPO Stakeholder]

The stakeholder from Diepkloof who mentioned sexual grooming as one of the problems also reported that, when they do school awareness campaigns, this is one of the topics they discuss with the girls. After the campaigns, some victims may approach the stakeholders who, in turn, report the matter to the local taxi association disciplinary committee as well as to the police:

> "What we did when we picked that up, we also went to some of the associations, the taxi associations. We have partnered with them. Every time we get a report, we go to them and report the case with them to the police. And then they say, if they get that report, they will release the person off their duties. They will lose their job." [NPO Stakeholder]

A participant in Emalahleni pointed out that women were generally not safe when using

public transport, particularly taxis. The stakeholder also explained that each local taxi association had a disciplinary committee focusing on issues of misconduct within the local taxi industry. She however stated that many of the crimes committed by taxi drivers or within the industry did not reach the committee because the public was not aware that there was such a structure in place. The response below provides an example of how taxi drivers commit GBV:

> "There are those drivers ne, you find that a woman is big and when she sits in front, he'd say 'I don't want a big one here in front, I request that you go sit at the back' or another would not want her in the taxi". [CBO Stakeholder]

A Sonke Gender Justice commissioned study conducted in 2019, in Gauteng and the Western Cape, highlighted sexual harassment, verbal harassment, and visual harassment as the type of GBV crimes committed against women who used taxis as a mode of transport. Sexual abuse perpetrated on women by taxi drivers while using taxis included rape, masturbation, and inappropriate touching; visual abuse included leering and staring at women inappropriately; and verbal harassment included shouting and using inappropriate language (Sonke Gender Justice 2020).

A stakeholder in KwaNdengezi reported the issue of *ukuthwala*. *Ukuthwala* (in IsiXhosa), *ukuganisela* (in IsiZulu) or *go shobedisa* (in Southern Sotho), "a form of forced marriage whereby a girl's parents open *ilobolo*[23] negotiations with a boy's parents" without the girl's consent (Mtshali 2014, p. 51). In addition, in communities, such as Shongeni and Zwelibovu in KwaNdengezi, families give their girl children for marriage as they believe that will make things better for their poverty-stricken families.

4.3 ISSUES AFFECTING VULNERABLE GROUPS

When participants were asked if GBV related services provided for victims from vulnerable groups were sufficient, the general response was "NO!" When asked which type of crimes are mostly committed against vulnerable groups in their communities, answers included child

[23] *Ilobolo* is a bride price, traditionally paid with cattle, by a man to a woman's family in exchange for her hand in marriage.

abuse (physical, sexual and neglect), rape and neglect of children and adults with disabilities, neglect and financial abuse of the elderly, verbal and physical violence, and homophobic or transphobic rape against members of the LGBTQIA+ community. Two sites, KwaMashu and Emalahleni, mentioned the killing of people with albinism to harvest their body parts for *muti*[24].

When stakeholders who participated in this research were asked whether the needs of child victims of GBV are catered for in their communities, most explained that, even though they are catered for, there are insufficient services for them.

> "No they [shelters] are not [enough], that's the main issue because they are not. Because sometimes when you call SAHARA[25] Centre with a request for them to remove a victim, you find that there is a waiting list and they are full. Aaaah! If they are full, for me, I remove children alone to the children's home. Even though the children's homes are also not enough, but we don't experience that much problems with waiting lists … So we figure out how we can, firstly remove children and then we try and figure out if there are relatives then the woman can go stay there. But we don't encourage for children to live with their relatives because they experience more abuse with relatives." [NPO Stakeholder]

Even though research participants explained that children's needs are always put first, the challenge relating to services offered to children was the limited number of places of safety as expressed in the quote above.

4.3.1 Persons with disabilities

Of all the project sites, three sites, namely, KwaMashu, Mbombela and Diepkloof had stakeholders in the network who focus exclusively on delivering services for people with disabilities. In KwaMashu, there are two organisations for persons with disabilities where one

[24] *Muti* is an isiZulu word for medicine. *Muti* is not medicine as known by the Western world but it is indigenous medicine concocted through traditional means and contains ingredients such as leaves, roots, bark stems, seeds, etc.

[25] SAHARA is a shelter for abused women and children situated in Phoenix, North of Durban.

focuses mainly on children and the other focuses on both children and adults. Both were part of the project. The stakeholder whose focus is mainly persons with mental health disabilities described the services her organisation offers:

> "What we are doing as social workers, if the child is born with mental disability, like if he's not talking, he's not walking, is not doing anything. There is a day care in our organisation where the children they are … they get stimulation. We also help them with the special school if they don't … if they don't know how to learn. We find them [schools for learners with special educational needs] to help them when they finish … schools there are workshops where they do … eh! … Where they work with their hands. We have nine workshops in KwaZulu-Natal. We also help the elderly who need residential facilities if there is no one at home who can look after them. So we do have residential facilities but they are few and they accommodate a few people because we are an NGO." [NPO Stakeholder]

The participant further explained that their residential facility houses up to 65 victims with mental disabilities of all genders who are between the ages of 17 and 55. When asked what happened to victims who needed a place of safety but did not fall within the above age range, the participant explained that they were referred to DSD. In addition to residential care, the organisation offers programmes where survivors learn various skills, counselling, stimulation, psychosocial rehabilitation, and special needs care for both children and adults. At the time of the interview, there were 10 economic development and empowerment workshops across KwaZulu-Natal with a capacity of 100 people each per day where survivors learnt manual skills or "how to work with their hands". When the stakeholder was asked for her opinion about the reasons people with mental disabilities were abused, she explained that perpetrators take advantage of the fact that they cannot easily express themselves or explain what has happened. Nevertheless, the participant added that it was not common for a person with disabilities to falsely accuse someone of violating them or identify a wrong person as the perpetrator.

> "Like I said in the beginning, we work with clients with disabilities, particularly rape cases. You find that offenders take advantage of the fact that our clients won't be able to speak in court. I would say those are our challenges as our organisation." [NPO Stakeholder]

Another participant, who represented a new organisation (not yet formalised) for people with disabilities, explained that their primary focus is to support parents of children with various forms disabilities.

> "Our group works with parents of [children with disabilities]. I am a parent of a disabled child myself. I have a 16-year-old child that is disabled. This is how I was introduced to this group … [our] group was formed for the support of the mothers and fathers of the children with disabilities. That is how I was introduced. We sort of realised that [the organisation] dealt with the children or people [with disabilities] and then the parents were left out … the group was formed for the support of the parents because every time there was a need that the children were maybe neglected. Because the mothers had no clue. They had no support." [CBO Volunteer]

Two factors highlighted in the excerpt above are: (1) Parents' lack of knowledge of the disabilities their children are with; (2) The lack of support for parents with children with disabilities. The participant further highlighted that these factors contribute to the parents' neglect of children with disabilities. When the stakeholder was asked to expand on the meaning of the term "neglect" in the context of her work, she explained that many parents hide their differently abled children from the community because they are ashamed of them. As a result, due to the lack of knowledge on how to care for these vulnerable children, they deny them their basic rights such as family and parental care, basic nutrition, basic health care, education, social care and protection. The participant further illustrated that, due to the parents' neglect, most of the children with disabilities did not go to schools or stimulation centres; some did not receive a disability social security grant and others lacked assistive devices such as wheelchairs, crutches, and hearing aids. Another type of neglect identified was the tendency by parents to leave children in the care of people who did not know how to look after a child with a disability which increases the likelihood for victimisation, mainly rape, of the vulnerable child.

> "Mainly rape. Rape of the child [with a disability]. It can be by the uncle in the home, it can be by the father in the home, it can be by the caregiver. Someone that they leave the child when they go to work. Also neglect. When they go to work, then leave the child with someone who just doesn't know what to do with the child." [CBO Volunteer]

The participant explained that parents with children with disabilities face many challenges related to access of services for their children and thus many of them give up hope. The stakeholder explained how frustrating it is to apply for a disability grant or to request an assistive device. She said that parents are often sent from pillar to post and that the process is made even harder because the child is expected to always be present. As most parents make use of public transport, children without assistive devices must be carried (regardless of how old they are) to these appointments by the parents.

> "And the embarrassment, when you have to ask for grant, they take you from pillar to post. You have to go to this, ja, go to the police station, go to SASSA [South African Social Security Agency]. You move around. Where else you have a child that doesn't walk and you don't have a wheelchair. You have to pick him up and go to the police station. You go with the child to open the grant. You have to take the child with. And then when you get to SASSA they say go to the hospital. The child is there. He or she is disabled. They can see but they tell you go to Rob Ferreira Hospital to get a letter. But, you see, there is the person that I am talking about. So those are the challenges we face in the process … it's too long. You get sent from pillar to post and when you get to Robs then send to SASSA, SASSA sends you to the bank because you need a bank account for the child. You then get to the bank; they give your forms and send you back to SASSA, then they say, after SASSA, come back to the bank. You see. You would have to go to Rob Ferreira Hospital; you go and apply for the assistive device and you get to be told that you are on a waiting list. How can you wait for legs when you need to go around? How can you be on a waiting list for a thing to live by it?" [CBO Volunteer]

The participant also expressed exasperation regarding the waiting period of getting a broken assistive device fixed.

> "[You wait for] months, and you find that parents will take a [broken] wheelchair to the car [mechanic] who is by the roadside fixing cars and ask him to fix. … You have to take it back to hospital and, if you go without them 'saying come next week to exchange for a new one'. Because if you take it first, you will be in for it. You will be carrying the child on your back all the

time." [CBO Volunteer]

"I think Masiphephe has their work cut out for them. Even other stakeholders, they still need to be educated. Because there's buildings, even government buildings, where you go and there is no ramp. You go to a building that has been there long and it's a government building. You come with the person with a disability, and you can't access the building. You see, we still need to bring everyone together to educate them in a lot of things." [CBO Volunteer]

In the above verbatim responses regarding the difficulties accessing services, the stakeholder underscores that some of the buildings where services are offered are inaccessible for people with physical disabilities, as they do not have ramps for wheelchairs, for example.

4.3.1.1 People with albinism

Another vulnerable group mentioned only in KwaMashu and Emalahleni was people with albinism who are murdered for harvesting of their body parts for *muti* purposes. This was attributed to the belief by some community members that body parts of people who live with albinism possess magical powers. During the interviews in Emalahleni, one of the participants discussed a high-profile case of a 14-year-old girl and a 15-month-old boy with albinism who were allegedly killed in February 2018. Three men who entered their home after breaking a window kidnapped the children from their home. One of the men explained in court that he consulted a traditional healer, who was one of the three suspects, requesting for help with *muti* to help his struggling tent rental business to grow after which he was advised to bring a child with albinism to the traditional healer (Mabona 2019). In KwaMashu, one participant narrated a story of a father who was asked by a traditional healer to sell his child with albinism to him.

"… also, the ones who work with body parts of albinos I do wish that we could intervene in that. One day there was a case here in Durban from Umkhanyakude District, eh, we found out about it through social workers and the community that there was a man who was unemployed; he had nothing in his home and he had albino children; the girl child was still at school, I think she was 16/17. So this man was talking, he is a fake traditional

> healer; he said that the father must sell him his daughter; he wants her hair and her eye; hair was maybe two thousand and an eye also will be two thousand. When they were talking, the girl child overheard and she told her mother. When the mother heard about that she became scared to ask her husband how he could do something like that. The girl child ended up telling the neighbour seeing the mother not doing anything, then the neighbour told the social workers then the matter was urgently attended to. Then the father ended up being unable to do that." [CBO Stakeholder]

Even though there were very few stakeholders in the project sites focusing solely on vulnerable groups, the participants explained that their services cater for all members of the community including the vulnerable groups. In a case where they cannot assist a victim due to a lack of skills in dealing with certain vulnerabilities, they refer the cases to professionals who are trained to deal with the specific issues.

4.3.2 The elderly

The main type of abuse perpetrated on the elderly is financial where family members use the pensioners' social grants for other, often selfish reasons, other than the elderly's primary needs. Grandchildren meant to care for their grandparents are often the perpetrators.

4.3.3 The LGBTQIA+ community

Participants from all sites admitted that their communities lacked knowledge about issues affecting members of the LGBTQIA+ community as well as their specific needs. All six sites reported that members of the LGBTQIA+ were often verbally abused or called names and were victims of homophobic rape, particularly lesbians. An example of a popular South African derogatory term used to refer to homosexuals is *"stabane".* Where homophobic rape is concerned, Naidoo (2018) reports that, on average, approximately 10 lesbians are raped each week in South Africa by men who claim to be "correcting" the women's sexual orientation or "curing" lesbians to make them heterosexual. Naidoo (2018) further explains that men who rape lesbians "who try to be like men" felt justified since they perceived their acts of violence as defending the authenticity of men (Naidoo 2018).

CHAPTER 5

5.1 SUPPORT STRUCTURES

This theme covers services that support individuals who respond to and prevent GBV. Discussions in this chapter will therefore be on the Masiphephe Network, referrals and follow-up, and trauma and skills.

5.1.1 Masiphephe Community Collaborative Network

This section covers participants' perceptions of the goal of Masiphephe, whether they had been part of a similar network before and what, in their opinion, will contribute to the success or failure of the network. Most participants reported that they had never been part of a network like Masiphephe before. The few who mentioned having been part of similar projects before were probed on the similarities and differences between the projects. This revealed that, unlike Masiphephe, previous projects were not evidence based and did not have a clear structure.

In general, participants had a good understanding of the primary aim and goals of the network. However, most of the participants felt a lack of ownership of the project as they believed that Masiphephe "belonged" to USAID, CCI, GHJRU and their community partners. The following were the common responses provided across all project sites regarding the goal of Masiphephe:

- Encourage collaboration in the prevention and response of GBV;
- Unite everyone working on issues of GBV to facilitate referrals and follow-ups;
- Encourage a GBV prevention approach that is people centred;
- Unite various stakeholders working with GBV issues to reduce GBV;
- Advocate and empower victims of GBV;
- Ensure that stakeholders operate effectively; and
- Educate the community about issues of GBV.

When participants were asked about their expectations of the project for both themselves as individuals and for their organisations, the following needs were shared:

- Gain more knowledge and experience on issues of GBV;
- Share knowledge with other stakeholders who were not part of the network and community members;
- For Masiphephe to provide a platform for advocacy not only for GBV but many other social ills experienced by the community;
- A transfer of skills between different stakeholders;
- Encourage government to be more involved in local matters, and to actively engage communities. The participants trust the Masiphephe project to engage with the higher structures in government to encourage change in communities;
- Strengthen stakeholder relationships.

The following were mentioned as factors that could contribute to the potential failure of Masiphephe:

- Mismanagement;
- Not having honest conversations and alienating men from conversations about GBV;
- Focusing on symptoms instead of the root causes of GBV;
- Not passing on the information gained in the network to the people who need it the most, the community;
- Lack of funding or sustainable sources of funding;
- Lack of communication between stakeholders;
- Lack of commitment from stakeholders; and
- Not working towards a common goal or the advancement of personal agendas.

On the other hand, the following were listed as factors that will contribute to the success of the project:

- Effective communication between various stakeholders;
- Disseminating impactful messages;

- Focusing on root causes and not symptoms of GBV;
- Stakeholders working together and supporting each other; and
- Allowing the community to share ideas about how they think their problems could be resolved (bottom-up approach).

5.2 REFERRALS AND FOLLOW-UP

A referral management system plays a vital role in victim empowerment as it keeps track of the survivors' referrals throughout the justice process. Moreover, the primary goal of a referral system is to improve and streamline communication between various stakeholders responsible for the care and support of a GBV survivor. The study found that all project sites, statutory departments and a few established civil society organisations had formal referral systems in place while most stakeholders had no formal referral systems. Even though statutory departments had referral systems, each department had its own referral management system that caused a duplication of services as survivors were sometimes referred to more than one stakeholder for the same service.

Similar to the referral management system, statutory stakeholders reported having follow-up systems such as holding monthly meetings with colleagues from different organisations or departments where feedback was provided; following up with the service provider to which the survivor had been referred; providing follow-up services to the survivor; or visiting the survivor at home. Participants from TCCs and DSD reported that they could effectively follow up on their cases since they offered survivors services for a prolonged period. The TCC, for example, keeps a survivor in the system for six months.

When participants were asked if they ever referred survivors of GBV to other services, such as spiritual counselling or traditional healing, the great majority reported that it was not within their discretion as professionals to make referrals for such services and that victims sought faith and belief services independently. When asked if the stakeholders worked with a formal network of pastors or traditional leaders and healers, the general response was negative. Based on this discussion, stakeholders in this project were not likely to explore alternative pathways to justice outside the formal justice system.

5.3 TRAUMA AND SKILLS

The study revealed that service providers working with GBV were highly susceptible to and experienced secondary or vicarious trauma. Statutory service providers reported that their organisations had psychosocial support systems in place that are available to all employees. Debriefing sessions with supervisors were listed as the most common psychosocial service offered to deal with work related trauma and burnout. However, support services for dealing with trauma and burnout were not compulsory or were not easily accessible, thus some participants opted not to use these services and preferred informal debriefings, for instance, with a colleague over a cup of coffee. While statutory service providers reported having access to psychosocial support, a considerable number of participants, who worked for CBOs and NPOs, reported not having access to any trauma and burnout services. When participants were asked how they dealt with the trauma caused by the work they did, they cited various approaches such as prayer, meditation, speaking with friends and family, and being counselled by a pastor.

5.4 TRAINING AND SKILLS NEEDS

When participants were requested to share the training and skills required to deal with GBV cases effectively, the following suggestions were made:

5.4.1 SAPS

- Statement taking for members of the SAPS especially those at station level;
- Intense DV and sexual offences training for members of SAPS;
- Customer service or victim support/empowerment training;
- Education on the use, understanding, interpretation of various GBV Acts;
- Administration skills;
- Training on the different National Instructions;
- Victim support and empowerment; and
- Handling cases of the vulnerable groups.

5.4.2 CBOs and NPOs

- How to handle GBV cases, to prevent secondary victimisation;
- Referral and follow-up tools;
- Reporting, monitoring and evaluation tools;
- Administration skills;
- Training on GBV; most stakeholders were doing work on GBV issues but did not have basic knowledge of GBV;
- Victim support and empowerment;
- Public finance management; know how to deal with finances and assets;
- Leadership skills;
- Communication and coordination skills;
- Advocacy;
- People management;
- Basic counselling/debriefing training;
- Train community health workers on how to handle issues of GBV; and
- Handling cases of the vulnerable groups.

5.4.3 Health care professionals (forensic nurses and doctors)

- Proper completion of the J88 form;
- Collection of evidence from a GBV survivor; and
- Proper handling of a GBV case.

When participants were asked to relate the one thing they would like to change in their community to improve the situation of women and children, answers included educating and empowering women vocationally (i.e., teaching women skills in the agricultural sector) and financially so they can be independent; providing parenting classes, teaching women self-love; and bringing back the lost spirit of *Ubuntu* where communities look out for each other and live collectively as a unit.

CHAPTER 6

6.1 RECOMMENDATIONS

6.1.1 All Masiphephe Network Organisations

6.1.1.1 Promote collaboration among organisations responding to and preventing GBV

The response to and prevention of GBV is not the work of the SAPS but requires a multi-sectoral coordination. Even though national and provincial government can manage social risks, very little can be done without the coordination of response and prevention efforts at the local government level. A core set of principles that respect and reinforce human rights and victim-centred approaches should drive stakeholder coordination where the needs of the survivors are the central focus of coordination. According to Hallfors, Cho, Livert and Kadushin (2002, pp. 244–245), for coalitions to be successful, they need to ensure the following:

- A collaboration must have clearly defined, manageable and focused goals;
- Collaborations should be evidence-led where response and prevention approaches are based on research data on what needs to change in the community;
- Communities ought to consider environmental programmes instead of only focusing on awareness and individually based strategies; and
- Ensure the quality implementation of programmes through continuous monitoring and evaluation.

One of the major benefits of effective coalitions is forming relationships, which facilitate referral and follow-up processes.

6.1.1.2 GBV and victim empowerment (VE) training

To enhance stakeholders' knowledge of issues relating to GBV and EV, it is recommended that foundational courses on GBV and VE be offered to stakeholders, more especially NPOs, CBOs and CCGs. CCGs, in particular, come into daily contact with members of the community who require assistance with activities related to their health and well-being therefore require VE training that includes the development of victim-centred response and prevention efforts (by

all stakeholders). The following are the benefits of victim empowerment as highlighted by Themba Lesizwe (2005 cited in Nel 2019, p. 91):

- Reduction of shock and trauma a victim may experience by offering emotional and practical support shortly after the incident;
- Identification of PTSD and referral of victims for trauma counselling and other psychosocial services;
- Prevention or reduction of secondary victimisation by the CJS by providing the victim with information such as the status of the investigation, victim's rights and how the court functions; and
- Prevention of repeat victimisation by guiding the victim towards a preventative lifestyle through the creation of awareness in the community of these crimes.

6.1.1.3 Challenging social/cultural norms

While there are many causes of GBV, one of the most common social risk factors identified at all six sites is harmful social/cultural norms. It is therefore recommended that cultural and social norms that support violence are challenged. Examples of such programmes are as follows:

- Community dialogues targeting all members of the community with the aim of correcting misperceptions and attitudes people have towards others. The community needs to work together to replace harmful sociocultural norms with new and healthy norms. Moreover, these dialogues need to focus on helping boys and men to develop masculine identities that are healthy and non-violent;
- Programmes targeting IPV and youth violence that aim to reduce dating violence among teenagers and young adults by challenging gender attitudes and norms that allow men to control women. Mass media campaigns or education through entertainment (edutainment) can be used to challenge norms that support violence (WHO 2009);
- Laws and policies that emphasis violent behaviour (WHO 2009); and
- The Department of Cooperative and Traditional Affairs (CoGTA) to monitor administration affairs of traditional communities to ensure that traditional leaders do not interfere with law-enforcement.

6.1.1.4 Other recommendations

- Provide training for CBOs, NPOs/NGOs, faith based organisations (traditional healers, churches, etc.), media and other stakeholders on the response to and prevention of GBV;
- Stakeholders dealing with GBV to familiarise themselves with relevant policies, strategies, and legislation;
- Ensure greater public awareness of victims' rights and expected minimum standards when accessing GBV services;
- Educate community members on the link between GBV and HIV/AIDS;
- Develop local monitoring and evaluation tools applied by all stakeholders to assess GBV prevention and response approaches and strategies applied by both statutory and civil society stakeholders;
- Create a multi-user referral and follow-up electronic platform for effective coordination between stakeholders. Also, investigate the services that are available in the community and create a referral directory;
- Encourage communities to develop informal social controls of GBV aligned first to the law and an integrated system applied by all stakeholders responding to and preventing GBV; and
- "[T]o combat diabolical and unethical behaviour by traditional healers such as muti murder, the Department of Health and other involved stake holders (the Traditional Healers Organisation, for example) need the development of a code of ethics and the registration of all those who practice as traditional healers in South Africa" (Thobane 2015, p. 166).

6.1.2 Criminal justice

- Make appropriate resources available to CJ role-payers; ensure that current structures, such as the SAPS DV and FCS Units, VFF, TCCs and SOC, are adequately resourced and capacitated;
- Effective and targeted training of both SAPS and CJ officials on how to deal with cases of GBV and how to offer victim-centred or survivor focused services. It is evident

from the results of this study that current courses offered to police officers are, firstly, not targeted and, secondly, not efficient;

- Structured and regular monitoring of the implementation of the National Instructions on Sexual Offences and other forms of GBV;
- SAPS statement on training and intervention;
- Training, monitoring and evaluation on collection and preservation of evidence by the police, follow-up with survivors, interviewing of survivors and witnesses;
- Monitor the backlogs of processing evidence by forensic labs; and
- Create a centralised and multi-user case tracking system that can link various statutory departments, such as the police, health and the courts, where all stakeholders can receive updated information on the status of a specific case.

6.1.3 Department of Social Development

6.1.3.1 Parenting skills classes

As shown in this study, poor parenting is one of the family risk factors attributed to the development of violent behaviour in children. As a result, supporting parents through parenting skills courses can be considered for the prevention and reduction of GBV. Thobane (2014, p. 208) explains that "parenting is a big responsibility and people often do not know how to go about fulfilling [this role]. As a result, many children suffer and grow up under harsh conditions characterised by abuse, lack of attention, and lack of love and care." Parenting does not happen in isolation but parents in South Africa face a host of challenges, such as poverty and unemployment, which constitute a risk for parenting (Gould & Ward 2015). Gould and Ward (2015) add that the lack of financial resources does not only affect parents' ability to provide nutrition, healthcare and education, it makes parenting very difficult and that parents who are struggling financially are more likely to be depressed. As a result, depressed parents are likely to utilise harsh (i.e., corporal punishment) and inconsistent punishment approaches (Gould & Ward 2015). It is thus important that parenting skills programmes offered to parents should not only focus on poor parenting but on the root causes, such as unemployment, as mentioned above. Since unemployment was mentioned in all the research sites as one of the community risk factors for violence, parenting courses

could also focus on offering economic development skills, which may reduce survivors' financial dependency on their abusers. In support of the latter, Gould and Ward (2015) posit that achieving milestones of the National Development Plan (NDP) 2030, which aims to reduce poverty and inequality in South Africa, will contribute to positive parenting.

Chapter 8 of the Children's Amendment Act (No. 41 of 2007) mandates early interventions towards the development of positive parenting. Section 114 highlights that capacity building of parents is in the best interest of their children (Gould & Ward 2015) by:

- Strengthening positive relationships with families;
- Improving care giving capacity of parents; and
- Using non-violent forms of discipline.

The South African Integrated Programme of Action Addressing Violence Against Women and Children 2013–2018 (DSD 2014) regards poor parenting skills to be one of the root causes of violence and thus focuses on strengthening early intervention approaches on the identification of high-risk children (i.e., truancy) and families (i.e., overconsumption of alcohol by parent/s). It provides comprehensive, multi-sectoral and long-term strategic approaches that prevent VAWC.

Ward and Wessels (2013) maintain that children whose needs are met during the early years of their lives succeed at school, have good relationships with others and become productive adult members of society. Parenting courses where parents acquire skills, such as giving clear instructions and exploring non-violent methods of discipline (i.e., time-out) instead of spanking, enhance the parent-child relationship. This is in line with the Constitutional Court of South Africa's banning of corporal punishment, on 18 September 2019, in the home.

The DSD is already offering courses that focus on parenting skills and children/teenager behavioural modification. As a result, it is recommended that these programmes be strengthened by developing a multi-sectoral team or approach where NPOs and CBOs can be brought on board by DSD to implement and facilitate these programmes in their communities.

6.1.4 Community, South African National Council on Alcoholism and Drug Dependence (SANCA); SAPS; Department of Basic Education (DoBE); and Media

6.1.4.1 Develop community-based programmes that prevent the abuse of alcohol and other substances

The overconsumption or abuse of alcohol and other substances was mentioned by all project sites as one of the biggest contributors to GBV. In addition, underage drinking and drug abuse were reported as part of the community risk factors in this research. Therefore, it is recommended that community-based programmes that focus on the prevention of underage drinking be developed and/or strengthened. Community-based alcohol prevention efforts, as explained by Fagan, Hawkins and Catalano (2014), are tailor made to local circumstances. Community-based efforts are owned and implemented by the local community and their aim is to reduce the misuse of alcohol through changing the environment (Fagan et al 2014). Furthermore, the programmes focus on decreasing risk factors (listed below) and elevating protective factors against alcohol use (Fagan et al 2014).

Multiple risk factors that increase the likelihood of alcohol use by children or young people have been identified from various research studies as follows (Fagan et al 2014):

- Individual characteristics (i.e., being aggressive at a young age or believing that the use of alcohol is not harmful);
- Peer influence (i.e., having friends who use alcohol or friends that believe that the use of alcohol is acceptable);
- Family influences (i.e., over consumption of alcohol by parents or siblings, inadequate parental supervision);
- School factors (i.e., failure, lack of commitment to school or education, truancy); and
- Community risk factors (i.e., availability of alcohol to young people [too many taverns in the neighbourhood], community permits underage drinking).

The following are some examples of alcohol use reduction community-based approaches:

(i) School based curricula

The DoBE to consider including, in the current life science curriculum, sections that deal with

alcohol abuse to alter school children's views regarding the acceptability of alcohol use, improve alcohol/drug refusal skills and encourage parent/child communication about alcohol use through homework (Fagan et al 2014).

(ii) Environmentally focused strategies

According to Fagan et al (2014), prevention efforts that could be included under this strategy are those that primarily focus on the availability and demand of alcohol such as "increased identification checks by retail liquor establishments and legal consequences for selling alcohol to minors." Moreover, policies and laws on alcohol use or liquor outlet operations need to be enforced and those that do not comply with the law must face consequences (Fagan et al 2014). Currently, this is the responsibility of the SAPS; however, community members need to play a more active role in this regard where tavern owners that do not comply with the law are reported to the police.

(iii) Awareness and prevention campaigns

More awareness and prevention campaigns on the abuse of alcohol and other substances to be conducted in communities as well as in schools. Social media and other forms of media could be used to spread the message wider and faster. SANCA, an organisation that already runs community development programmes in rural and peri-urban areas and has adopted the Community Anti-Drug Coalitions of America (CADCA), should play a leading role in the treatment of the abuse of alcohol and other substances.[26] Therefore, it is recommended that SANCA's existing seven coalitions in rural and peri-urban areas be strengthened and expanded. In addition, there were no representatives from SANCA during both the CCN workshops as well as the interviews and thus it is recommended that the organisation be approached to become part of Masiphephe. Other stakeholders that focus on the abuse of alcohol and substances should also be recruited.

[26] CADCA builds and strengthens the capacity of community coalitions to create safe, healthy, and drug-free communities. It supports members with technical assistance and training, public policy, media strategies, conferences, and special events (Substance Abuse and Mental Health Services Administration 2020).

GLOSSARY OF TERMS AND DEFINITIONS

Gender

Gender is associated with personal identification such as lesbian, transgender, gender-neutral, non-binary, cisgender, agender, pangender, genderqueer, heterosexual, homosexual, transgender, intersex, or any combination of these.

Gender based violence (GBV)

GBV is violence that is directed at an individual based on one's gender identity. GBV includes physical, sexual, verbal, emotional, and psychological abuse, threats, coercion, and economic or education deprivation whether occurring in public or private life. The term GBV does not mean woman abuse, which is a sub-type of GBV. Therefore, the two concepts should not be used interchangeably because boys, men, and gender minorities, such as members of the lesbian, gay, bisexual, transgender, queer, intersex and asexual (LGBTQIA+) community, also experience GBV.

The types of GBV are defined in-depth under the types of domestic violence (DV) (see section 4.2).

Domestic violence (DV)

The Domestic Violence Act, No. 116 of 1998 (DoJ & CD 1998) defines domestic violence (DV) as: physical abuse; sexual abuse; emotional; verbal and psychological abuse; economic abuse; intimidation; harassment; stalking; damage to property; entry into the complainant's residence without consent; and any other controlling or abusive behaviour towards a complainant where such conduct harms, or may cause imminent harm to the safety, health, or wellbeing of the complainant.

Table 5: Types of DV

Type of abuse	Definition
Physical Abuse	Slapping, beating, arm twisting, stabbing, strangling, burning, choking, kicking, assaults with an object or weapon, and murder.
Sexual Abuse	Coerced sex through threats, intimidation, or physical force, forcing unwanted sexual acts or forcing sex with others.
Emotional, Verbal and Psychological Abuse	Threats of abandonment or abuse, confinement to the home, surveillance, threats to take away custody of the children, destruction of objects, isolation, verbal aggression, and constant humiliation.
Economic Abuse	Acts such as the denial of funds, refusal to contribute financially, denial of food and basic needs, and controlling access to health care, employment, etc.
Intimidation	Uttering or conveying a threat, or causing a complainant to receive a threat, which induces fear.
Harassment	A pattern of conduct that induces the fear of harm including repeatedly watching, or loitering outside the complainant's home, work, business, place of study or other places; repeatedly making telephone calls or getting another person to make telephone calls to the complainant (whether conversation ensues or not); repeatedly sending, delivering or causing the delivery of letters, telegrams, packages, facsimiles, electronic mail or other objects.
Stalking	Repeatedly following, pursuing, or accosting.
Damage to Property	Wilful damage or destruction of property belonging to a complainant or in which the complainant has a vested interest.
Entry into the complainant's residence without consent	Where the parties do not share the same residence
Any other controlling or abusive behaviour towards a complainant	Conduct that harms, or may cause imminent harm to the safety, health, or wellbeing of the complainant.

Source: DVA (DoJ & CD 1998)

Intimate Partner Violence (IPV)

IPV is domestic violence in an intimate relationship perpetrated by either a current or former spouse or partner against the other spouse or partner.

Sexual offence

The South African Sexual Offences and Related Matters Amendment Act, 2007 (No. 32 of 2007) (DoJ & CD 2007) defines sexual offences as sexual activities without consent and refers to a wide range of sexual behaviours leading to the victim feeling uncomfortable, afraid or threatened. Sexual offences thus include rape (penetrative), sexual assault (non-penetrative), attempted sexual assault and contact sexual offences.

A person who has experienced any of the following sexual offences is protected by the SOAA (DoJ & CD 2007):

- **Rape** refers to sexual penetration of the genital organs including the anus or the mouth of another person without consent of the person;
- **Sexual** grooming takes place when one educates, introduces, or prepares a child or an individual with a mental disability to perform or witness any sexual act or become sexually ready;
- **Incest** is sexual intercourse between people who are closely related or are from the same immediate family;
- **Child pornography** occurs when a child is used for publishing pornographic material; and
- **Child prostitution** when one forces a child or a person with mental disabilities to engage in sexual activities for a purpose of attaining a reward or exposing the victim to pornography.

Victim

A victim is a person who has been harmed or killed because of GBV. A **survivor** is a person who is in the process of overcoming the harmful impact of GBV. For this study, the terms victim and survivor are used interchangeably.

Violence against children (VAC)

The World Health Organization (WHO 2020) defines violence against children (VAC) as all forms of violence perpetrated by parents or caregivers, peers, romantic partners, or strangers against people under the age of 18. Furthermore, VAC entails at least one of the most common types of interpersonal violence, which may occur at any stage of the child's development (WHO 2020).

Table 6: Types of VAC

Type of Abuse	Definition
Maltreatment	Violent punishment, physical, sexual and psychological/emotional violence; child neglect in homes and other settings such as schools and orphanages.
Bullying	Repeated physical, psychological, or social harm taking place in schools and other settings where children gather as well as online (i.e., cyber bullying).
IPV	Commonly happens against girls in child marriages or forced marriages. Often occurs among child marriages but can also take place between unmarried adolescents that is called dating violence.
Sexual violence	Non-consensual completed or attempted sexual contact or other sexual acts not involving contact (i.e., voyeurism "peeping tom" and sexual harassment); sexual trafficking; and online exploitation.
Emotional or psychological abuse	Restriction of movement, mockery, threats and intimidation, discrimination, rejection, and other forms of hostile treatment.

Source: WHO (2020)

Violence against women (VAW)

VAW is described by the United Nations (UN 1993, p. 3) as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring

in public or private life". Furthermore, gender violence includes but is not limited to:

> [p]hysical, 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 (UN 1993, p.3).

Included under the types of VAW is **femicide**, which is broadly defined as any intentional killing of women and girls because they are women.

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