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Qualitative Research Report: Local Governance to Improve Gender-Based Violence (GBV) Response

Abbreviations and Acronyms

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
CCN	Community Collaborative Network
CCGs	Community Care Givers
CJA	Child Justice Act
CJS	Criminal Justice System
CoGTA	Cooperative Governance and Traditional Affairs
CPF	Community Poling 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
DSD	Department of Social Development
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
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

FSL	Forensic Science Laboratory
FOVOC	Foundation for Victims of Crime
GBV	Gender-Based Violence
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 Case 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 of Gender-Based Violence and Femicide
NVEP	National Victim Empowerment Programme
OSC	One Stop Centre
OSS	Operation Sukuma Sakhe
PEP	Post Exposure Prophylaxis
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
VAWC	Violence Against Women and Children
VAW	Violence Against Women
VC	Victim's Charter
VOD	Victim Offender Dialogue
VEP	Victim Empowerment Programme
VFF	Victim Friendly Facility
WHO	World Health Organization
Wits-RHI	Wits Reproductive Health Institute

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INTRODUCTION AND BACKGROUND

Centre for Communication Impact (CCI) - Masiphephe Network: 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 is *to reduce vulnerability to GBV through improved local governance and service delivery;* with a strategic objective 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' at the coalface of GBV in selected sites in the three provinces. Integrated interventions are aligned to achieving the tenets of the White Paper on Safety and Security (2016), and the National Strategic Plan on GBV and Femicide (2020 – 2030); 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 of GBV; to facilitate the objective of building safer communities in South Africa as set out in the National Development Plan (NDP).

In order 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. Subsequently, findings from this research may serve as a guideline in the evaluation of the project sites' community response 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. In connection to the primary aim(s) of the study, the research objectives were to identify:

- the roles local organisations that deal with GBV issues play.
- 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.
- support required by individuals employed by organisations dealing with GBV issues.

LITERATURE REVIEW

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- **Nature and extent of GBV**

While women and children (more especially girls) are disproportionately affected by GBV - GBV affects anyone regardless of his or her geographical location, social and economic status, race, religion, culture or gender identify. A 2012 study conducted by Gender Links revealed that 77% of women in the Limpopo province, 51% in Gauteng, 45% in the Western Cape and 36% in KwaZulu-Natal have been victims of some form of GBV. Also found in the same study was 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). The latter findings are concomitant with results from a research done with 1 394 men working for Cape Town municipalities where about 44% of the men admitted to abusing their female partners (Abrahams, Jewkes & Laubscher 1999).

Research by Abrahams (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 Limpopo have, in their lifetime, experienced physical abuse committed either by their current or ex-partner. Further revealed by this study was that 51% of women in the Eastern Cape, 50% in Mpumalanga and 40% in Mpumalanga experienced emotional and financial abuse in a year prior to the study (Abrahams 1999).

As depicted by Figure 1 on the next page, the SAPS recorded 179 683 cases of VAW and 45 229 cases of VAC during the 2018/19 reporting period. [1]When the three provinces where this study was based are compared with each other, the highest number of VAW cases reported in 2018/19 can be attributed to Gauteng (n=45 238) followed by KwaZulu-Natal recording 25 963 incidents and Mpumalanga accounting for 9 398 cases. Together, the three provinces contribute 45% (n=80 599) to 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 by the KwaZulu-Natal province while 2 865 cases were reported in Mpumalanga. Similar to VAW incidents, Gauteng reported the highest number of VAC when the three project sites are compared to each other. While Gauteng is the smallest province out of the three and in the country by area, it is the highest contributor of VAWC cases reported to the police 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 or the financial centre of South Africa. Accordingly, the province has the biggest population due to migration since entrepreneurs and job seekers from not only other provinces within the country but from other countries as well come to the city of Johannesburg because of opportunities it offers (Fourie 2016). However, services do not increase with the population and thus great demand be placed on available services can potentially cause various social issues.

For the purpose of this report, GBV crime types that will be focused on in the discussion of literature are sexual offences, physical abuse (i.e. assault - both common and assault grievous bodily harm [GBH]) as and murder.

[1] Due to the fact that, at the time of completing this report, the SAPS Contact crimes statistics for 2019/2020 were not disaggregated, the 2018/2019 statistics were utilised throughout this report.

Sexual offences

Based on the crimes statistics by the SAPS rape is attributed to the majority of the sexual offences cases reported between the three-year period from 2016/17 – 2018/19. Moreover, 41 583 cases of rape were recorded in 2018/19, which is an increase of 3.9% when the reporting year is compared the previous year (SAPS 2019).

Figure 1: SAPS VAWC 2018/19 cases

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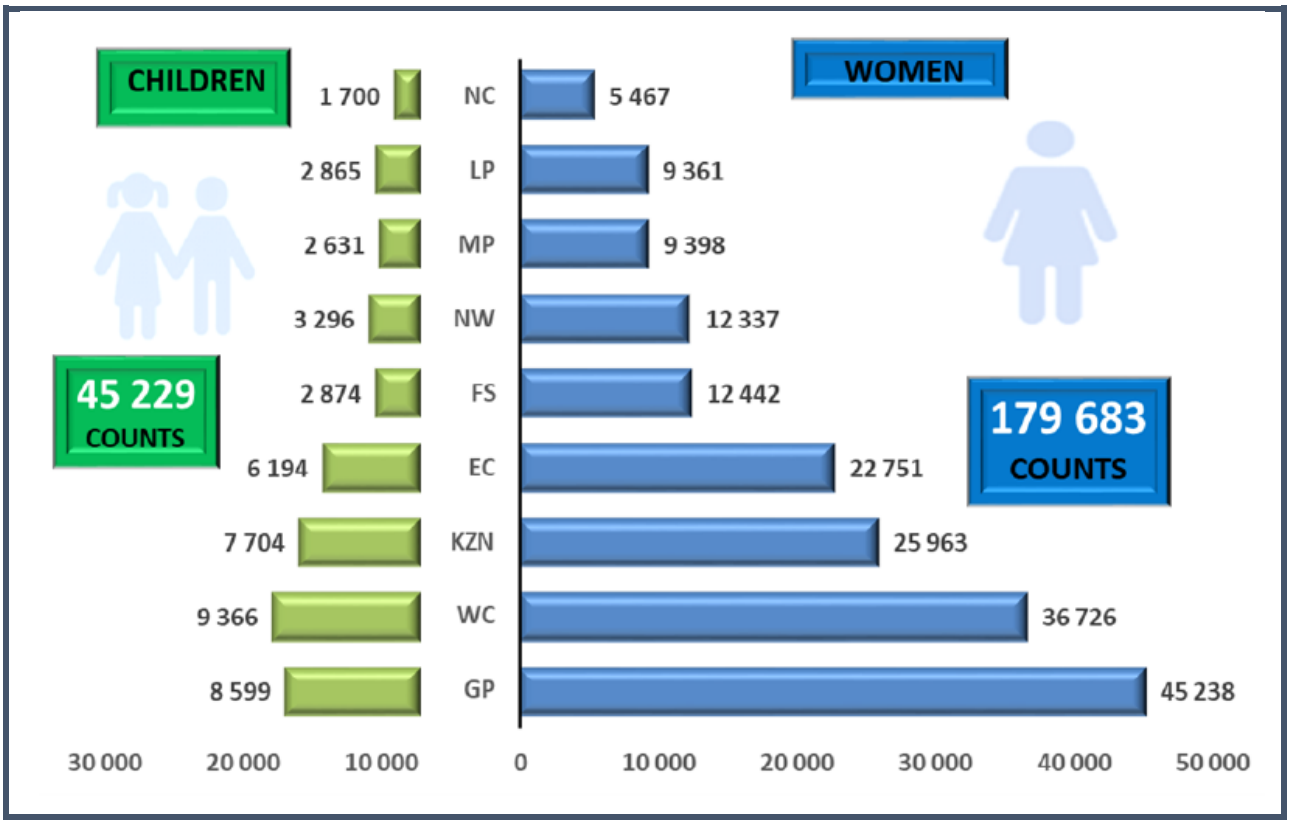
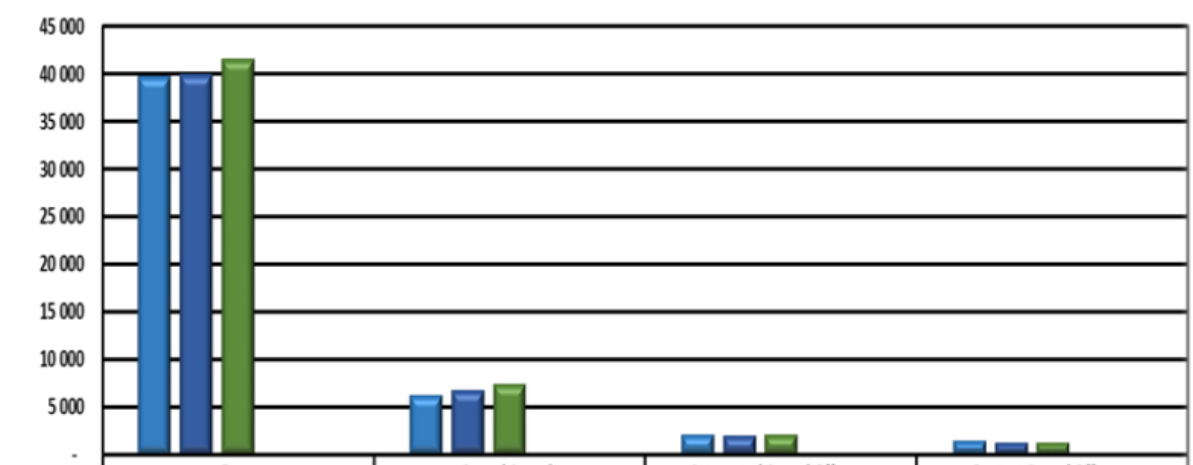


Source: SAPS (2019)

In terms of gender, women experienced more rape in all three of the provinces where the project is taking place accounting for a combined total of 16 720 rapes reported 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 females were victims in 90% of the cases (n=5 895) while in comparison to 10% cases (n=674) reported by males (SAPS 2020). Likewise, of the 2 590 rape incidents recorded in Mpumalanga in 2018/19 females were victims in 2 348 cases whereas males were victims in 242 of the incidents.

Additionally, in 2018/19 girls were raped more often than boys were. In the rape justice in South Africa research conducted by the South African Medial Research Council [SAMRC], it was revealed that 46% of rape cases were of child victims (Machisa, Jina, Labuschagne, Vetten, Loots, Swemmer, Meyersfeld & Jewkes 2017). In approximately 84% of rape cases of children, perpetrators are men known to children such as school teachers for example (Machisa et al 2017) while 40% of adults were raped by a stranger. Moreover, in 90% of all cases (children and adults included), perpetrators were male (Machisa et al 2017).

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) <all full citations>

Where other vulnerable groups susceptible to rape are concerned, the elderly (60 and older) had an overall total of 1 284 cases recorded by the SAPS in 2018/19 (SAPS 2019). In rape study by the SAMRC (2017), 4.9% of victims were living with disabilities. It is, however, reported in the same research that rape of children living with disabilities is under-reported.

Sexual assault contributed the second highest number of cases (7 437) towards sexual offences recorded by the SAPS in 2018/19. Children's vulnerability to violence rises from the fact that they depend on adults, parents or caregivers for the growth and well-being. 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% reported having experienced some form of sexual abuse at some point in their lives, that is one in three young people. At the time of the latter research the total population of South Africa was 53 million people and children under the age of 18 made up 35% of the population (n=11.6 million). Subsequently, based what was revealed in the study by Artz et al (2016) it means approximately 784 967 of children between the ages of 15 and 17 in South African have experienced some form of sexual abuse. Moreover, 40% of the young people who participated in the study 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 on type of crime.

Where provincial statistics are concerned cases of sexual assault reported in 2018/19 increased in seven (7) provinces except in the Western Cape and North West 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 the 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 are 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 insurmountable to understand the extent of sexual offences against the LGQBTQA+ is.

- **Phsical 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).

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

Based on the above explanations, 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 against women decreased by 6 001 incidents in 2015/16 in comparison to the previous year. However, the number of incident reported in 2017/18 increased by 3 052 from the previous reporting period. The increasing trend persisted into 2018/19 where 1 586 cases more were reported when 2018/19 is compared to 2017/18.

The harm suffered from assault GBV is grave and has negative effects on the victim. Victims of GBV suffer serious injuries, which have severe effects to the health of the victim such as broken bones or permanent body disfiguration and as such recording over 50 000 incidents annually since 2015/16 (SAPS 2020) is worrying. An analysis conducted by the SAPS in Gauteng and Mpumalanga has shown 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 a 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 some kind of physical assault from their current partners (Jewkes, Levin, Mbananga & Bradshaw 2002).

Matthews, Martin, Coetzee, Scott and Brijmohum (2016) explain that physical violence of children in the pretext of discipline is common in South Africa and is accepted by many as a normal parenting practice. In agreement with the afore-mentioned, a recent study conducted by Richter, Mathews, Kagura and Notnterah (2018) conducted in Soweto, where Diepkloof is situated, 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 at 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.

- **Murder**

Reported by the SAPS is that the majority of victims and offenders during murders cases during 2017/18 were males. However, the SAPS reported that in 2017/18 the number of murders of women and children showed a notable increase of 12.6% (n=437). Due to the increasing trend and ferocious murders of women in South Africa, the government has declared femicide in South Africa a national crisis. Based on the below 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 Arica. In addition, Table 2, on the next page, 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) were reported in KwaZulu-Natal whereas Eastern Cape reported the second highest number (n=730) followed by Gauteng (n=657).

Table 2 on the next page shows that where the project sites are concerned more children are killed in KwaZulu-Natal (n=221), followed by Gauteng (n=108) then Mpumalanga (n=46).

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 the crime in 2017/18. Furthermore, the two most common weapons used during the commission of murder in 2017/8 were firearms used in 6 651 of the cases and knives used 4 868 times (SAPS 2018). Abrahams, Jewkes, Martin, Matthews, Vetten and Lombard (2009) report that the most common methods used to kill women in incidents of IPV range from blunt force trauma, sharp objects, firearms, strangulation, burns, drowning and asphyxiation. According to the SAPS (2018), the majority of murders take place during weekends when people are socialising at home or places of entertainment, with the associated use of alcohol. Streets or highways were identified as the most common places where murders took play across all provinces in 2017/18. In Mpumalanga, 11% of victims were killed in open spaces (veldt/bushy areas). Another common place where murders took place in KwaZulu-Natal, Gauteng and Mpumalanga and is a place of residence, reporting 26.3%, 24.2% and 15.7% respectively.

A noteworthy number of homicides took place in taverns or *shebeens*.[3] 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).

[3] 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.

Table 2: Provincial overview: Murders of women and children 2017/18

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 (2019)

Causes of GBV

The prevalence of GBV in South Africa, as well as globally, is rooted in the historical systemic gender inequality and discriminatory heteropatriarchal[4] practices that disempower women, girls and other gender minority individuals. Notwithstanding the afore-mentioned, it is widely accepted that there is no straight answer 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 one from committing crime in the presence of a risk (Herrenkohl, Hawkings, Chung, Hill & Battin Pearson 2001). As explained by Krug, Dahlberg, Mercy, Zwi and Lozano (2015), GBV is caused by an interaction between individual, community, economic, cultural and religious factors interacting at different levels of the society. Heise, Ellsberg and Gottmoeller (2020) posit that factors that influence one at an individual level range from growing up in a violent home, to having an absent father or a lack of a positive male role model. Both boys and girls learn violence and thus young people who grow up in violent homes normalise violent behaviour as a means of communication even later in their

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

relationships (Holt, Buckley & Whelan 2008). Risk factors associated with an increased risk for sexual victimisation for young people who participated in the study by Artz et al (2016:11) 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 respondent shared a room)." At community level, factors that contribute to the perpetuation of VAW are violent neighbourhoods that view VAW as a cultural or religious norm, abuse of alcohol, and gun ownership. In SAPS murder cases alcohol is found as one of the multiple generators of crime. Even though the consumption of alcohol is not the problem, the abuse of alcohol and other substances bears a negative impact on rational thinking and behavior as a result 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). Important to note is that poverty in itself does not cause crime, the impact of poverty on crime involves a complex interrelationship between a number of variables on an individual and community level.

While it is important to focus on factors that cause GBV to better understand the etymology of the 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 in Artz et al (2016) research included parents knowing who their children spend their time with, how their children's time is spent and where they go. 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.

Impact of GBV

As explained by Mpani and Nsibande (2005), GBV is both a human rights and public health issue does not only affect the individual but also has an impact on the survivor' 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 or early labour or injury of a foetus in a pregnant woman or death (Mpani & Nsibande 2005). Experience of GBV can lead to mental health problems such 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. Further reported is that girls who have experienced sexual abuse are at a high risk of developing sexual behaviours that make them vulnerable to revictimisation while sexually abused boys are at a high risk of developing risky violent behaviours later in their intimate and non-intimate relationships (Artz 2006). Artz et al (2006) additionally found in their study that one-fifth of children who are sexual victimised by adults were at a high risk of experiencing problems with schoolwork or school attendance.

Additionally, GBV also bears financial implications for both the survivor and the state. Because of GBV, survivors and their families often spend money seeking for 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 KPMG (2014) "Too costly to ignore - the economic impact of gender-based violence in South Africa" study estimated that GBV costs South Africa between R28.4 and R42 billion annually, or between 0.9% and 1.3% gross domestic product (GDP) annually (Khumalo, Msimang & Bollbach 2014).

- **Sexual and reproductive health**

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

VAW is one of the major factors contributing to the ill-health of women and 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 biggest HIV epidemic in the world. The United Nations Programme on HIV/AIDS (UNAIDS) reports that 7.7 people 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 South African National Prevalence, Incidence and Behaviour Survey, 2012 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 2019:2). 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[5] sex (Mabaso et al 2019).

A South African study on the associations between IPV and HIV risk behaviour where 1 275 young men from 70 villages near Mthathha in the Eastern Cape were interviewed, revealed 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, Jewkes, Nduna, Levin, Jama, Khuzwayo, Koss & Duvvury 2006: 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; more especially if one is in an abusive relationship.

The following are according to the Unite Nations Population Fund (UNPFA n.d.) 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.

Furthermore, substance abuse may also contribute to an increase in HIV risk behaviours and GBV as discussed previously.

Mpani and Nsibande (2015) expound that planning and modern contraceptives provide women with the choice and an opportunity to make informed decisions about their own lives. Through family planning young women are able to prevent falling pregnant in their teenage hood or too early in life and thus reduce pregnancy complications, or maternal and child mortalities (Mpani & Nsibande 2015). According to the UNPFA (n.d.) IPV is an obstacle towards the use contraceptives and condoms and as a result denies them their reproductive rights as well as the right to sexual health. Oftentimes women whose partners oppose

[5] 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."

family planning seek for "invisible" contraceptives such as hormonal injections that will not be noticed by their partners. Also reported is that 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 negotiation for safe sex may lead to unplanned pregnancies and unsafe abortions.

Prevention of GBV

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

> 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 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-centered 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 (Rauch 1999).

According to the South African Government (2020), the aims of the NCPS are to:

- Establish 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.
- Create dedicated and integrated crime prevention capability 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 level.

The NCPS is based on four pillars, namely, strengthening of the CJS, reducing crime through environmental design, introduction of initiatives that encourage public values and education. These are unpacked in the section that follows. However, tor the purpose of this report, attention is focused primarily on pillar one.

Pillar 1: Strengthening the CJS

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

- increase the efficiency and effectiveness of the CJS as a deterrent 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;

- improve service delivery by the CJS to victims by being sensitive to their needs (South African Government 2020).

To attain the above-mentioned goals, eight key programmes were identified. However, for this study only the Victim Empowerment Programme (VEP) focused on.

An important document where VEP is concerned is the Service Charter for Victims of Crime in South Africa, hereinafter referred to as the Victims' Charter, a vital instrument utilised to promote justice for survivors developed from NCPS as well as the 1998 National Victim Empowerment Programme (NVEP) (Department of Justice and Constitutional Development [DoJ & CD] n.d.). According to the DoJ and CD (n.d.), the Victims' Charter promotes justice for all and is complaint with the Constitution of the Republic of South Africa (Act No. 108 of 1996) and the United Nations (UN) Declaration of Basic Principals of Justice for Victims of Crime and Abuse of Power, 1985. Moreover, the Victims' Charter highlights the rights of the victims where criminal justice services are concerned. The services which victims are entitled to in terms of their rights listed in the Victims' Charter are highlighted in the Minimum Standards Services for Victims of Crime (MSSVC) developed in 2004. 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
- The right to restitution (DoJ & CD 2020).

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

Pillar 2: 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 (South African Government 2020).

Pillar 3: Public Values and Education

Pillar 3 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.).

Pillar 4: Transnational Crime

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

Moreover, in an effort 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, the UN Convention on the Elimination of All forms of Discrimination against Women. Furthermore, various legislation 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)
- Children Act, 2005 (No. 38 of 2005)

The National Strategic Plan of Gender-Based Violence (GBVF) and Femicide (NSP) was promulgated in 2020. The aim of the NSP is to:

> "provide a multi-sectoral, coherent strategic policy and programming framework to strengthen 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. The strategy seeks to address the needs and challenges faced by all, especially women across age, sexual orientation, sexual and gender identities; and specific groups such as elderly women, women who live with disability, migrant women and trans women, affected

> and impacted by the gender-based violence scourge in South Africa" (Republic of South Africa 2020).

The NSP is built on the following pillars:

> Pillar 1: Accountability, Coordination and Leadership
> Pillar 2: Prevention and Rebuilding Social Cohesion
> Pillar 3: Protection, Safety and Justice
> Pillar 4: Response, Care, Support and Healing
> Pillar 5: Economic Power
> Pillar 6: Research and Information Systems

The GBVF National Strategic Plan (2020-2013) was developed in February 2019 as a result of the Presidential Summit on GBV which took place in November 2018. The purpose of the GBVF National Strategic Plan provides a unified strategic framework meant to guide the response and prevention of the GBV and femicide crisis in South Africa.

Challenges with the CJS

It is well known and is shown in the preceding discussion that South Africa has effective policies to address GBV, but the limitation is in the 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 range from lack of resources (i.e. shortage of police officers and/or stations, limited trained officials specialiing in GBV, vehicles, etc.), secondary victmisatiion of victims and attrition rate of GBV cases.

- **Secondary victimisation**

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

> ✓ Disbelief of the person's account
> ✓ Blaming the victim
> ✓ Lack of (or insufficient) services at interpersonal, institutional and broad social level to support to the victim." (DoJ & CD 2006:2).

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

- **Attrition of cases**

Attrition in the criminal justice refers to 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 **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.
- ✓ **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.
- ✓ **After the trail** 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 2017:20).

In 2003, a study on 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 both of the High Courts in the province, and 30 magistrates' courts.

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

- 'Half of cases resulted in arrests (50.5%) but only 42.8% of perpetrators were charged in court.
- Trials commenced in less than one in five cases (17.3%).
- A conviction for any crime resulted in just over one (1) 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 2018).

In 2003 and 2006 Artz and Smythe conducted two studies. They examined the disposition of 1 600 rape cases across six urban police stations. Smythe and Artz's analysis of rape cases showed that there is a considerable variance from station to station and court to court. 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%) cases.
- 2 579 (65%) were referred for prosecution.
- Prosecutors accepted 1 362 cases (34.4%) which were enrolled for trial.
- Trials started in 731 (18.5%) cases.
- 340 (8.6%) cases 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 in the attrition of cases through the Criminal Justice System resulting in fewer convictions. Whilst the annual police statistics indicate the high numbers of reported cases, the conviction rates remain very low.

<separate chapters>

METHODOLOGY

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 employs oppressive and colonising behaviors such as using indigenous[6] knowledge without permission or for personal gain of which the researched do not benefit" (Snow, Hays, Caliwagan, Ford Jr, Mariotti, Mwendwa & Scott 2016:359). However, 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 (Jewiss 2018). In essence, the transformative paradigm highlights that research should not perpetuate inequality and injustice but should play an explicit role in the identification and alleviation of discrimination (Jewiss 2018). The specific method used in this study is the Khupe's transformative community-based research. Sachez-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 was conventionally not validated as knowledge (Sachez-Betancourt & Vivier 2019:376). Betancourt and Vivier (2019: 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 role of knowledge producer.

This research was collaborative in nature and relationships based on mutual respect were forged between the researchers, the community partners as well as the participants. Community partners played a role of elders[7] because of their knowledge of and closeness to research subjects or the communities in which the study was conducted.

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

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

Figure 3: Khupe's framework for transforming research methodology

Source: Khupe (2014; 2020)

Even though participation in this study did not bear 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 a role of cultural guides by assisting the researchers, specifically field workers, to 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 and it turn allowing collection of in-depth data. As explained by Ngũgĩ Wa Thiong'o (2005:13) 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 an individual is granted an opportunity to speak in their own language he/she is provided an opportunity to both communicate and reflect on personal experiences embodied in his/her culture. Khupe (2014) adds that language constitutes intellectual and cultural resources for indigenous communities and is key in the transmission of indigenous knowledge.

Sampling method

Stratified sampling was utilised to sample participants for this study. This sampling method is used when the population has mixed characteristics and one wants to ensure that every characteristic is proportionally

represented in the sample. One then divides the population into subgroups or strata based on the relevant characteristics. The Masiphephe Community Collaborative Network (CCN) in each of the project site was, at the time of this research, subdivided into three task teams or strata, namely Criminal Justice (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 site assisted with the selection process and through their help, it was ensured that the sample represented the characteristics of the overall Masiphephe population. In addition, from the six CCNs we selected the sample using purposive sampling. 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 characteristics of individuals who have knowledge on 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. As a result, 80 individuals from 40[8] organisations were sampled from a Masiphephe overall population of approximately 195 individuals and 148 organisations across the three provinces and six communities. Important to note is that in qualitative research sample sizes are smaller as the purpose is to generate thick descriptions of the data and in-depth analysis as opposed to quantifying the results or producing statistics based on a large sample.

Table 3: The number of research participants per site

<s. spaced table content>

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**

[8] 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.

Data collection

Two forms of in-depth qualitative data collection methods, semi-structured interviewing and focus group (FG), were utilised to collect primary data from the 80 stakeholders who took part in this study. Face-to-face semi-structured interviews were conducted with 46 participants; 21 participants from Alexandra and Deiepkloof were interviewed individually through the telephone; two (2) participants self-administered the interview schedule by completing it electronically; one (1) stakeholder did his interview via ZOOM; and one focus group (FG) comprising 10 social workers from ADAPT was facilitated in Alexandra. The use of FG as a data collection method in Alexandra is attributed to time constraints. In addition, due to service delivery protests that took place between April and May 2019 in Alexandra, some data in the area was 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 pronounced the national lockdown. Various lockdown restrictions including travel bans for both personal and business reasons were imposed and in turn led to the telephonic interviewing of seven (7) participants out 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 (see ANNEXURE A). Even though the interview guide was developed in English, participants - especially in Mpumalanga, KwaZulu-Natal and Diepkloof - 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 these sites was an added advantage since, where necessary, the questions were explained in research participants' home languages. On the other hand, there is a possibility that some meaning may have been lost in translation and 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 CCN workshops. Secondary data were collected from the literature.

Data analysis

The data collected was analysed using thematic analysis. The first step entailed transcribing the audio recordings verbatim. Interviews conducted in vernacular (Sesotho, isiSwati and isiZulu) were simultaneously translated into English by two researchers during the transcription process. Furthermore, a deductive thematic analysis approach as emphasised by Braun and Clarke (2006) 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), each of these themes were accompanied by subthemes (refer to the findings section). The final phase of the analysis process entailed writing this research report. To ensure trustworthiness of the findings, brief fact checking follow-up interviews were conducted via the telephone with some of the research participants as well as the community partners.

Ethical practices

The UCT's Health Sciences Faculty Haman Research Ethics Committee approved this project. Moreover, the following ethical practices were maintained throughout the research process:

- **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 clarity seeking questions where necessary. Finally, after the interviewee indicated that they he/she fully understands the content of the form it was signed and dated by both the researcher and the participant. The consent form is attached to this report as ANNEXURE B.

- **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 on research participants.

However, research has a potential of being 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, respondents 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 stakeholders were reminded of their right not to answer any question they felt would make them feel uncomfortable.

- **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.

- **Confidentiality and anonymity**

Confidentiality and anonymity are two ethical issues that are very important where social research or research involving human participants is concerned. Confidentiality was persevered throughout this study by ensuring that confidential information shared by the research participants is only available to the GHJRU research team. All hardcopy documents containing confidential information (i.e. consent form 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. Even though complete anonymity could not be maintained because the fieldworkers had face-to-face contact with the research participants, during either 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.

Study limitations

- **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 local stakeholders involved in the local response and prevention of GBV.

- **Limited knowledge of GBV**

It was realised during workshops as well as in-depth interviews that some stakeholders, particularly CBOs and NPOs, had limited knowledge of GBV issues. Consequently, their limited knowledge on the topic led to their interviews being concise and lacking important details. On the other hand, the issue of language could have been a possible barrier where some participants may have not been able to fully express themselves in English. To counter act the latter the researcher at five of the sites was able to speak most of the South African languages and thus allowed interviewees who were not comfortable with English to conduct the interview in their mother tongue. The same approach was adopted during the CCN workshops. Additionally, in KwaMashu one of the GDF colleagues sat in some of the interviews in order to assist with the translation of some of the questions participants may have found difficult to understand.

- **Self-reported data**

As recounted before, data were collected from 80 participants across three provinces using semi-structured interviews and a focus group. Consequently, data were self-reported. Self-reported data has limitations in that they rarely can 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 one's personal agency and attributing negative events or failures to factors out of one's control); (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 the interviewing of multiple participants allowing for comparison of different interviews to each other for similarities and contradictions.

- **Findings not statistically representative or generalisable**

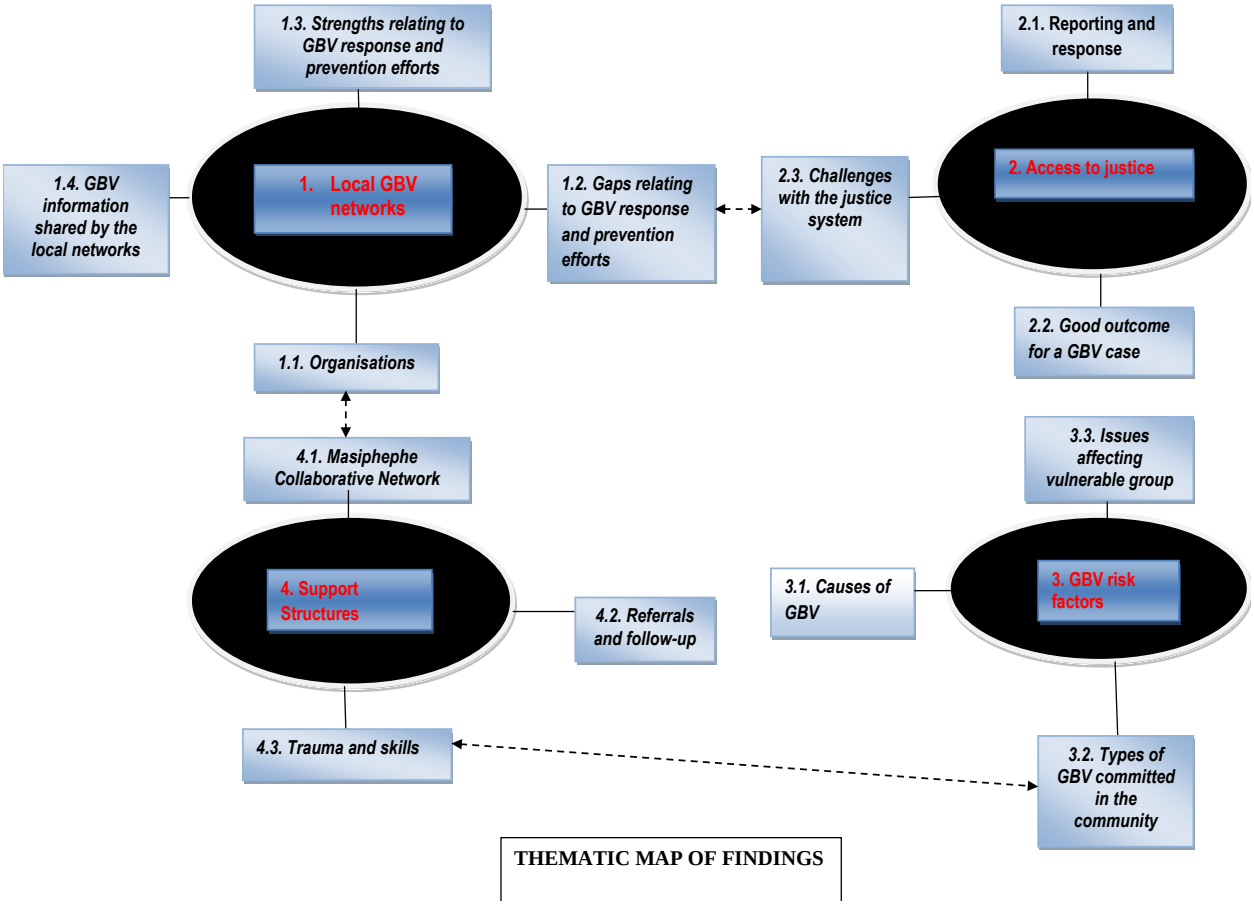
The aim of a qualitative study is to gain a deep understanding of a specific phenomenon or topic based on the perspective of research participants rather than focusing on numerical data and generalising findings

across the entire population. In order to collect in-depth qualitative information data is collected from only a few individuals while quantitative statistical tests require larger sample sizes in order 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 on 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.

EXECUTIVE SUMMARY OF FINDINGS

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

Figure 3: Thematic map of findings



- **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. The findings show that the majority of the organisations represented in the network deal with crime prevention at either primary (i.e. awareness campaigns, community outreaches and dialogues, etc.); or secondary level (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 tertiary level (i.e. Courts, DCS, Diversion Programmes Organisations).

Even though collaboration efforts were 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. Stakeholders further reported poor attendance of GBV programmes, withdrawal of cases by victims, unsafe communities and interference with law enforcement by traditional and/or community leaders as barriers they face in the community when rendering services.

Gaps relating to GBV response and prevention efforts ranged from the lack of resources (i.e. training, police vehicles, police stations, comfort packs, lack of funding for NPOs and CBOs) to services, particularly by statutory organisations, being far away from the community.

The common strengths across all three provinces were collaboration between various stakeholders and the Thuthuzela Care Centre 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 distance of police station from the community were all provide as reasons why people do not report GBV.

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

- The lack of communication in the local GBV networks makes the referral and follow up of the cases challenging and inefficient, as a result several cases are withdrawn along the way due to a long chain of referrals with lack of coordination between the service providers.
- Except for the TCC and DSD where survivors are seen for a prolonged period, the majority of stakeholders 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 and experience secondary trauma. While statutory service providers reported having access to psychosocial services, a considerable number of participants who work for CBOs and NPOs reported not having access to any trauma and burnout services. In general, participants had a good understanding of the primary aim and goals of the network and are optimistic that it will succeed.

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

detention sentence, while the next individual may feel that justice was served after receiving holistic victim empowerment services, which facilitate healing. In addition, justice to someone else could mean a combination of the former and the latter.

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

GBV risk factors

Domestic violence against women, specifically IPV (i.e. rape, physical, emotional or verbal violence and financial) was reported as the main GBV crime experienced in the communities. After women, children were said to experience various forms of violence such as neglect, sexual and physical abuse in the domestic setting where in sexual offences perpetrators are usually male members of the family (i.e. brothers, fathers, stepfathers, uncles). Stakeholders in KwaNdengezi and Diepkloof reported sexual grooming of young schoolgirls by taxi or scholar transport drivers who after impregnating the girl abandons both the mother and the child. Where vulnerable individuals are concerned, rape of both children and adults living with mental disabilities ware 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 corrective rape, of lesbians. Participants admitted that improvements needs to made on support services relating to the vulnerable groups. Especially for people living with disabilities and the LGBTQIA+ community.

Like previous studies on GBV, it has been found in this research that no single **risk factor** causes violence, but rather a plethora of risk factors are associated with violent behaviour. The ecological model, which presents GBV risk factors at the individual, family, community and society, was utilised in the attempt to determine the causes of GBV across the project sites.

On an **individual level**, it was found that children learn violence within their violent homes. Moreover, the over consumption of alcohol by either one or both of parents often leads to the 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 of both parents, disagreements between parents about child rearing or discipline, 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 who do not abide by the Liquor Act 59 of 2003. It was reported that some of these liquor outlets operate illegally without a license, ignore operational hours or sell alcohol to children. The latter was identified by participants in KwaNdengezi and KwaMashu as a contributing factor to 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*, Xanex (antidepressant) and *incika* (a mixture of Spar Letta Sparberry soft drink and Codeine, an over the counter cough syrup).

<chapter headings>

FINDINGS

THEME 1: LOCAL GBV NETWORKS

This theme focuses on the organisations participants work for and how the organisation deals with matters related to GBV as well as collaborative efforts between local networks

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The theme is further sub-divided in the following sub-themes:

Sub-theme 1: Organisations

Sub-theme 2: Gaps relating to GBV response and prevention efforts

Sub-theme 3: Strengths relating to GBV response and prevention efforts

Sub-theme 4: GBV information shared by the local networks

1.1. ORGANISATIONS

As elaborated on before, 80 participants from 40 organisations participated in this research. Stakeholders represented in this research can grouped into three main categories Public Sector (n=12), Civil Society (n=27) and Private Sector (n=1). The category of stakeholders which was the most represented is the 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.

Table 4: Participant stakeholders

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	8. CPF 9. DCAG 10. Hlahlindlela 11. Mawethu Community intervention Solutions (Diepkloof) 12. Reach for Life 13. CPW	16. Johannesburg Region E Business Forum

7. Local government (City of Johannesburg/Mbombela/EtheKwini)	14. OSS 15. Siyaphambili Community Forum	
Schools	**NPOs/NGOs**	
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 Organisation	
	OVC	
	40. Durban and Coastal Mental Health	

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 what role their organisation play in response and prevention of GBV, the responses fell within the three categories of crime prevention, 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 which category of organisation they worked for, reported engaging in primary crime prevention approaches or deterrence activities, which take place before GBV is committed. Various

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

1.1.1 Collaboration between local GBV networks

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

Stakeholders, 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 Thuthuzela Care Centre (TCC) approach that enables various individuals from different organisations to work together towards achieving the same goal of turning GBV victims into survivors.

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

- **Disconnect between stakeholders (working in silos)**

Stakeholders in all the sites identified this challenge. It was explained that the reasons why stakeholders are pulling in different directions is because there is a lack of communication, commitment and passion in their work by some stakeholders. Also emphasised was that each organisation has its own institutional goals to achieve which further perpetuates the disconnection. One participant from KwaNdengezi, one in KwaMashu and one other in Mbombela emphasised this challenge by stating that due lack of integration between government departments, services are often duplicated.

> *"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 in to 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]

- **Lack of political will**

Reported specifically in KwaNdengezi, Alexandra and Mbombela is that even though GBV is at the top of the priority list for national government, there is 'lack of political will' from local government to tackle GBV issues. Also expounded on is the fact that when new political leaders take office they discontinue initiatives started by their predecessors and introduce new projects. As a result, continuity and sustainability of programmes is hampered. Moreover, representatives from such organisations (mainly government) cannot participate in activities without permission being granted by 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 different protocols followed by different departments can be a hindrance for stakeholder coordination.

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

When participants were probed on the challenges and barriers they face in the community where activities related to the response and prevention of GBV are concerned, the following were listed:

- **Poor attendance of GBV programmes**

Reported mostly by participants from Emalahleni, KwaNdengezi, Diepkloof and KwaMashu is that attendance of programmes such as outreaches, dialogues and workshops by community members is poor. As a consequence, information is not cascaded effectively and thus lack of information on GBV issues and support services by the community prevails. When asked what, in their point of view, are the reasons why community members do not attend GBV programmes, the unanimous response was that members of the community expect an incentive (i.e. lunch, cap, T-shirt, etc.) 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**. It was said that institutions and stakeholders dealing with GBV do not get a 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]

- **Withdrawal of cases by victims**

Withdrawal of criminal cases was mentioned across all sites by both the police and other stakeholders as one of their biggest obstacle. Findings from a USAID commissioned study on improving case outcomes for sexual offences project (ICOP) conducted by the GHJRU show 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, it must be pointed out that 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 or the offender's family or the community and therefore the victim fears for his/her life. This finding corroborates reasons found by Machisa et al (2017) during SAMRC study (refer to the literature section). Other reasons reported for withdrawal of cases by victims ranged from 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; to the offender being the breadwinner thus the victim fears that if he/she is found guilty and is sentenced to imprisonment then a source of livelihood will be cut. These interlink with the reasons why individuals do not report GBV. These reasons were reviewed in the literature will be again expounded on later in this section.

- **Unsafe communities**

A worrying revelation was the issue of the safety of stakeholders when they go into communities to run GBV programmes. It was reported in KwaNdengezi, KwaMashu and Emalahleni that some areas are deemed crime hotspots as such it is difficult to effectively deliver GBV services to those communities. Reported in KwaNdengezi by all participants who took part in the research and during workshops is 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 skwatta camps is so* [dangerous] *some areas like here in Witbank are Old Coronation… 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 it's somehow lacking".* [Statutory Stakeholder/SAPS]

> *"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/Municipality]

> *"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/Social Worker]

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

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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 kids, as such hostels were created for men so that they could live close to their workplaces while their families (wives and children) were left behind in the rural areas (influx control). It is for this reason that men in this study 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 (Xulu-Gama 2012). 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 (South African

Government 2020). Women and children thus started living in hostels through the CRU programme. However, women staying in the KwaMashu hostel were not completely welcomed by everyone and this caused tension between hostel dwellers. Firstly, men blamed women for the increase in unemployment for men living in the hostel because women are more likely to be employed in comparison to 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 can be linked to young men's romantic involvement with the women who visit 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 2017:6). The main dispute rose as a result of women being allocated spaces in the new family CRUs before men who felt they should have been a priority as they lived in the hostels before women (Xulu-Gama 2017:6).Shockingly, Xulu-Gama (2017) found that women who lived in the hostel blamed their victimisation and abuse by men on their decision to live in space meant for men. The most disturbing revelation was that if a woman gets 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 2017:6). Xulu-Gama (2017:6) further explains that in most cases, women are blamed for the murders because it is believed that they are not behaving themselves.

Insecurity caused by criminality

Xulu-Gama (2017) explains that hostel residents revealed that they have fear of being targeted and that their anxiety rises when they hear gun shots in the hostel. Furthermore, hostel dwellers in this research were of the opinion that violence in their space is random and anyone could be a victim. However, it is also mentioned in the study that some residents believed that the violence in the hosted is rooted in power games where the one holding the power is targeted by those who feel they should be at the forefront of hostel activities such as allocation of rooms and choosing which families 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 motivation. The crime situation at the hostels is also highlighted by the SAPS as one of the reasons why the 2017/18 murder rates were higher in KwaZulu-Natal (SAPS 2018)

Insecurity caused by political climate

Historically, "the KwaMashu hostel is known as a place of war between political parties" (Xulu-Gama 2017:7). Xulu-Gama (2017) posits that even though this particular hostel has a history of the Inkata Freedom Party (IFP) stronghold, members of other parties such as the ANC and other political dwelled 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 hostel feeling more threatened.

- **Interference with the formal justice system by traditional justice systems**

In order to understand how culture can be harmful to the community or play a role in the perpetuation of GBV, it is important to first to provide a conceptual clarification. Culture refers to values, beliefs, language and practices shared by a group of people. Moreover, culture is made up of rules, norms, laws, and morals that govern a community or the society. Additionally, culture plays a significant role in the society because it enriches people's quality of life and improves the general welfare for both an individual as well as the community. There are many positive cultural practices, which are socially beneficial and can be used to prevent GBV. These include social or cultural norms[9], which promote unity and equity in communities. One such practice is the African philosophy of *Ubuntu* meaning humanity. *Ubuntu* translated "I am because you/we are" emphasises the importance of humanity towards 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 cultural or social norms, which perpetuate GBV. Found in Mbombela, KwaNdengezi and KwaMashu is the interference of community and/traditional leaders (*IziNduna*[10] or Chiefs), especially in the rural areas, with the formal justice system. Explained was that one cannot gain access to the community without first going through the community or traditional leaders. It was reported that community leaders go to an extent of preventing law enforcers from entering the community in order to investigate serious cases of GBV as it is believed that issues in the community can be resolved without involving the formal justice system. It was said that this is attributed to the cultural norm that one should not air their dirty laundry in public translated into Swati by one of the participants in Mbombela as "*Tibi tasekhaya atikhishelwa ngaphandle."* What exasperates the law enforcers about the meddling with the law by traditional leaders are the inappropriate sanctions imposed on the offender- by the traditional leaders – which do not match the severity of the crime and the lack of victim support and justice for the survivor.

[9] As explained by the Gender and Development Network (n.d.) "social norms are beliefs, held by groups of people, about the way they must at to be an accepted member of the society. Social norms are the 'unwritten rules' that show the values that a society holds dear and that govern how people should behave in a given context or situation."
[10] IziNduna, plural for Induna, is a Zulu title for advisors, leaders, headmen who act as a bridge between the community and the King.

> *"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/Law Enforcer]

While traditional leaders may be of the view that law enforcers make a mockery of their culture and undermine their authority, law enforcers in this research were of the opinion that traditional leaders need to understand that *"culture has its place but also has its limits, especially when it comes to issues of violence."* <Note for copy edit: insert findings> <Recent research conducted by the Tshwaranang Legal Advice Centre (TLAC) confirmed the above findings regarding interferes by traditional justice systems with the law. Please note that I was unable to open the report sent by Mariatu.>

GAPS RELATING TO GBV RESPONSE AND PREVENTION

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In this section, the various gaps concerning response and prevention by stakeholders are identified.

1.2.1 Gaps relating to government stakeholders

- **Lack of resources**

The lack of resources was cited by various statutory stakeholders at all sites as one of the barriers that prevents them for delivering services effectively. The three main resources, which were said to be lacking in order to successfully respond to and prevent GBV, are trained police officials, shortage of police stations and limited police vehicles.

- ✓ **Lack of police officials trained to deal with GBV:** It was emphasised that most police officials (especially at station level) lack training and knowledge on how to handle GBV cases. This was reported as 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 as previously discussed. The main points of contention raised where the lack of training of police officers were around statement taking, secondary victimisation of survivors and incorrect completion of the SAPS 308 form.
- ✓ **Shortage of police stations:** It was found in Mbombela, KwaNdengezi and Alexandra that some community members have to 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) in order to improve access to police

stations by the affected community members. Access to justice and the police will be discussed in-depth towards the end of this report.

- ✓ **Limited police vehicles:** All police officials who participated in this study reported that the lack of enough police vehicles is one of the primary reason that hampers their responding to cases of GBV as quick as they should. Also explained in KwaNdengezi and Mbombela is that when police vehicles are booked for service they are only returned after a week or longer as there is usually only one workshop that services the vehicles in the area. The latter thus intensifies the already existing problem of limited vehicles. Lack of police vehicles was also previously identified as a challenge where coordination of GBV response efforts between the different stakeholders is concerned. Emphasised was that the lack of police vehicles extends the victim's waiting period at the Client Service Centre (CSC) at the station which has a very negative impact on the victim and 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 that 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/Social Worker]

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

Still on the issue of the lack of vehicles, it was found that there is no vehicle dedicated to the TCC at the RK Khan Hospital situated in Chatsworth, KwaZulu-Natal. It was explained that officials at the centre are expected to go into communitLiies to conduct awareness campaigns but they do not have the means, in the form of transport, to reach communities. In addition, TCC officials are unable to fetch victims who do not have their own transport but have 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, as mentioned previously, police officials (FCS officials included) whom TCC colleagues rely on for transportation of survivors have 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 resort to using their own personal vehicles in order to render services to the community. It is for this reason that a participant in Diepkloof stated that:

> *"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.

- ✓ ***Lack of psychosocial services*:** One of the social workers interviewed in Emalahleni and another one in KwaNdengezi revealed that they struggle when there is a need for a further referral of survivors requiring more intensive-psychotherapy by a psychologist. Two reasons attributed to this challenge are, namely, 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 does not have money who are earning low that 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 […]"* (NPO Social Worker).

> *"*[…] *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 2 we* [are an] *NPO, because they can charge like round about R2500 per session for one child* […]*"* [NPO Social worker].

> *"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 kind 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 resource. Like those specialised Units like the FCS. [Participants 1 interject: 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/SAPS].

- ✓ **Shortage of comfort packs for sexual offence survivors:** Two participants, one from KwaMashu and one from Mbombela, highlighted that there are not enough comfort packs for survivors of sexual survivors 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. The need for comfort packs is emphasised in the below word for word 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 consists of sanitary pads and you know few toiletries that you can take a bath, including a clean underwear. Because most of the time when a case is new and you come in still 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/SAPS].

> *"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 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 Deoxyribonucleid 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.

- ✓ **Lack of sexual assault (evidence collection) kits at TCCs:** Very few criminal offences require an examination and collection of evidence as extensive as what is required from a sexual assault crime (Acino Forensic 2020). With the exception of assault GBH, no other crime collects nearly as much evidence from a survivor like a sexual offence (Acino Forensic 2020). As such, evidence

collection kits are a very important tools in a sexual assault investigation. The importance of having sexual collection kits at the TCCs is explained by one of the Site Coordinators as follows:

> *"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."* [Statutory Stakeholder/TCC]

The above response by the TCC Coordinator raises a serious issue that needs to be investigated. It is revealed by this stakeholder that that sometimes victims are unable to access services such as r medical examination within 72 hours after being raped, for example, not because of their own doing, but due to the lack of urgency by and coordination between CJ role-players.

In connection to evidence collection, another challenge identified by an official employed by the FSC division of the SAPS is **the delay in processing of DNA evidence by the forensic labs** 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 specimen that will be collected from the, 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/SAPS]

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.

- ✓ 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. 'Cause you find that a Dr. will say to you like the other day when I was on standby 'I am not trained on examining a rape victim.'"* [Statutory Stakeholder/Law Enforcer]

> *"And sometimes you go there to the casualty you ask the Dr. to assist you and the Dr. 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/TCC].

In addition to the lack of training of some Drs to examine a rape survivor, it was reported that some Drs do 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 Dr.? Why are you there? And some will come and assist and yet make mistakes and complete J88 incorrectly. 'cause 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 Drs write? So those are the things. So if they can receive a workshop or some kind of training only on that.*" [Statutory Stakeholder/SAPS]

The J88 form is a legal document which is completed by a medical doctor/district surgeon or a forensic nurse in order 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 Protectiion 2020). As emphasised by Dr Kyle Wilson quoted by Medical Protection (2020), even though Drs may loathe 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.
- ✓ Size or approximate size 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.
- ✓ Lack of understanding of medical terminology.

- **Services far from the community**

It was found across all the project sites that while there are services (i.e. primary healthcare, CCGs, police stations, CBOs, etc.) available within the community, most services (especially medicolegal, psychosocial, shelters/places of safety) are not easily accessible to community members. It was found in Mbombela that there is only one forensic nurse at the Mbombela clinic providing services to the whole community. In Alexandra it was reported that the nearest TCC is in Tembisa, another township which is 24 kilometres (km) away from Alexandra. However, there is 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 a satellite office inside the Wynburg[11] 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.
- ✓ Taking of a statement and keeping the victim informed about the case by an Investigating Officer (Investigating Officer) from the SAPS.
- ✓ Placing survivors in shelters/places of safety.

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

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

In addition, due to the fact that medicolegal, counselling and shelter services are mostly provided in town, community members are thus required to travel from their areas of residence to access the services. This is considered a serious gap because the high level of poverty and unemployment in the research sites means that survivors often do not have transport fare to access services. The afore-mentioned was said, by research participants, to also be 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 has to take money from her own pocket or ask for donations from colleagues to prevent her clients from 'dropping out' of their counselling sessions. Another identified gap also associated with the high dropout rate of victims from the CJS is the **lack of effective referral processes between stakeholders** <del B throughout: sing quotation> which frustrates victims and their families as they are often sent from pillar to post. A more in-depth discussion of the current referral and follow-up systems utilised by stakeholders in this project will take place under the last theme at the end of the research report.

1.2.2 Gaps relating civil society organisations

- **Lack of funding**

Reported in Emalahleni, KwaNdengezi, Mbombela and Alexandra is the issue of the lack of funding experienced mostly by NPOs and CBOs which results in volunteers not being paid and stakeholders struggling with paying for venues, for example, to have meetings or host events.

- **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/Social Worker]

> *"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 your home as a social worker* […]. *"* [NPO Stakeholder/Social Worker]

Further mentioned as a gap by one participant in KwaNdengezi which could be said to be relevant to other project sites is the lack of support and shelters for men who are 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/Health Care]

- **Lack of appropriate training for, skills and knowledge of GBV issues by CBOs/NPOs**

Picked up at all sites during workshops was that some stakeholders, specifically CBOs and NPOs, have very limited knowledge of GBV issues. This observation was corroborated by research participants in Mbombela, KwaNdengezi, Alexandra and Diepkloof. Expressed as a concern was that when one does not have the proper training and skills to deal with issues of GBV they expose both the community and survivors to incorrect messages which, in turn, causes unintended harm.

> *"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 Social Worker].

1.2. STRENGHTS RELATING TO GBV RESPONSE AND PREVENTION EFFORTS

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

KwaNdengezi

- The TTC OSC model or having different stakeholders/departments under one roof to prevent sending sexual offence victims from 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 gender based violence services and issues being free and accessible.
- Services are close to the community.
- Stakeholders and organisations collaboration and working together through platforms such as the Operation Sukuma Sakhe (OSS). OSS also referred to as War Room: A neutral platform where

various stakeholders meet on a regular basis to discuss community issues which include gender based violence.

KwaMashu

- The FCS in collaboration with TTC ensure immediate attendance to GBV cases and effective support of survivors.
- The police respond quickly to cases if vehicles available.
- Interdisciplinary team of forensic nurses, SAPS, DSD, Lifeline and Childline for trauma debriefing of GVB victims.
- Most male traditional healers know 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 is speeding up 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.
- There is a buy in from the community where tacking issues of GBV is concerned, many community members want change and are going above and beyond programmes organised by stakeholders to ensure that change does take place. , organisations are getting stronger in dealing with GBV.
- The Masiphephe project is seen as a strength for the community.

Mbombela

- The police station is near for easy access by community members.
- The Greater Rape Intervention Project (GRIP) that has a counsellor situated at Nelspruit hospital and in the TCC at Kabhokweni hospital as well as in Masoyi and Hazeyview 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 [to] successfully obtain necessary health services, prosecute offenders [i.e. court preparation] and recover physically, emotionally and mentally with immediate, on-location services in police stations and hospitals, and via extensive in-home post-assault services" (South Africa HIV and AIDS Regional Exchange [SHARE] 2013:Np).

- Masiphephe project is viewed as a mind opener to stakeholders for issues related to GBV.
- The TCC situated in Kabhokweni hospital was identified as the biggest strength, especially due to the fact that victims' need for support can be hindered by organisations offering the necessary support being situated in different places and thus becoming inaccessible to victims due to the lack of transport fare. Additionally, the full 2-days course of Post Exposure Prophylaxis (PEP) medication is now provided to victims on the first visit to minimise medication defaulting victims who do not have transport fare to go back to the TCC to fetch their medication.
- Door to door outreach being conducted by the SAPS was said to be one of the strengths since community members are granted a chance to understand that police officers 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 information about.
- Collaboration between various stakeholders through OSS.

Emalahleni

- TCC seen as the biggest strength for the community of Emalahleni. Through the TCC, survivors (both children and adults) have easy access to the police, shelters or places of safety and counselling services.
- Foundation for Victims of Crime (FOVOC) offers 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 are able to sustain themselves financially post the GBV experience.
- Conviction rate has increased. This was attributed to the fact that the justice system has improved communication with the community regarding their cases (i.e. postponement, etc.). This was perceived as empowering to victims.
- Collaboration between the various stakeholders working on issues of GBV.
- Disciplinary actions taken against taxi drivers who abuse passengers by the local taxi association.
- More organisations dealing with GBV
- KHULISA Social Solutions an NPO which focuses on inspiring, empowering and offering of diversion programmes to offenders and vulnerable children or children/youth in conflict with the

law in order to unleash their potential and hone their skills towards 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 2020).

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

- Conducting community outreaches or *izimbizo*[12] increases the community's awareness to issues of GBV.

Alexandra

- Stakeholder collaboration.
- Services offered by Medico-Legal as previously discussed in-depth under gaps.
- ADAPT working hand in hand with the police, doing door-to-door bringing awareness to the community.
- ADAPT is one of the first women organisations in the country to engage men as part of the solution to addressing violence against women. We have male social workers offering counselling and support services to men who are mostly perpetrators of violence against women.
- Radio programme: ADAPT has a very good working relationship with the local radio station – Alex FM. This enables the organisation to educate the community about issues pertaining to human rights, gender-based violence and the importance of utilising available counselling services.

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

- ADAPT managed to forge a good working relationship with the Department of Education and the local schools. That enables ADAPT to have easy access in schools to help address issues pertaining to sexual violence and bullying in schools. Apart from facilitating training sessions and workshops for learners, educators and ground staff, ADAPT has social worker and an auxiliary social worker offer counselling and support services to learners in schools
- ADAPT is also assisting schools to operationalise schools' safety policies/frameworks to enable management of unacceptable behaviour in schools
- ADAPT has six accredited facilitators, moderators and assessors who offer various trainings whenever a need arises.
- ADAPT comprehensive counselling and support services for victims of GBV are strategically located in the community for easy access. Counselling and support services are offered at the Victim Empowerment Centres based at the Sandringham Police Station, Alexandra Police Station and will soon be extended to the Bramley Police Station.
- ADAPT has the arts and healing project. Various art forms are used to help clients heal from their issues bothering them.

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 the listeners are encouraged to call in to participate in the conversation.
- FCS at Protea Glen Police station responds effectively to cases of GBV and offers victim empowerment.
- Integrated and holistic support services (i.e. medico legal and psychosocial) offered at the Naledi TCC Baragwaneth Hospital. In addition, social workers based at the NTCC ensure that rape victims the assistance they require within 72 hours of being victimised.
- People Opposing Woman Abuse (POWA) NGO being 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 different stakeholders with different expertise.
- The bringing together and empowering of stakeholders by the Masiphephe project. It was also explained the collaboration of stakeholders enabled by the Masiphephe has in turn improved the referral process between the various stakeholders.

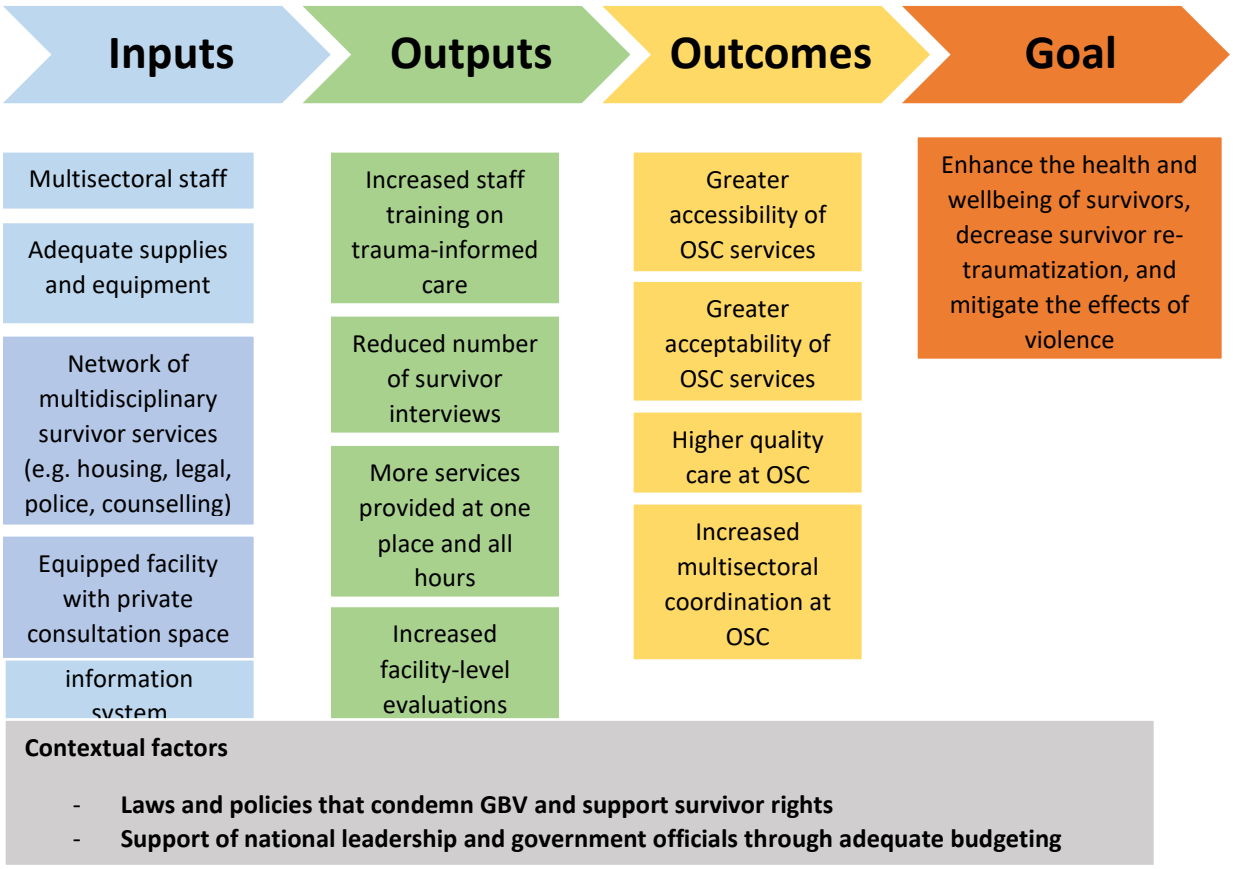
- Facilitation of stakeholder of collaboration by SONKE Gender Justice.
- Men's training programme in Meadowlands Sport Clubs in partnership with Jozi FM where teenage boys are taught gender confidence, communication skills and empathy. The programme also focuses on teaching the community at large about GBV through the use of radio.
- The community has become aware of the Masiphephe project and stakeholders who are part of the network.

A closer analysis of the above listed strengths per site revealed that two strengths being 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. It is clear from the above discussion and previous discussions 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 sexual offences. As explained by Olson, Carcía-Moreno and Colombini (2020:33) the OSC model is designed to "provide effective, multidisciplinary, coordinated and survivor-centred care to survivors" Olson et al (2020:2) 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). 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 come into contact with 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 2020:2). The strength of the TCC as an OSC is summarised in the below verbatim response by one of the participants who is a TCC site co-ordinator:

> *"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"* [Statutory Stakeholder/TCC].

The diagram on the next page on the theory of change of the OSC by Olson et al (2020) 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 TTCs and to secondly evaluate whether TCCs in their current state are effectively achieving what they were developed for.

Figure 4: OSC theory of change



Source: Olson et al (2019:3)

1.3. INFORMATION SHARED BY GBV LOCAL NETWORKS ON GBV

When asked what channels are 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 is an art and culture organisation named Isimilo Production that spreads the message about GBV 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 most research participants expressed earlier in this section that community members do not attend GBV programmes and in turn the information on GBV is not effectively cascaded, it is peculiar

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 used to raise awareness on diverse and social issues. Social media is characterised by high-speed 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, taking advantage of 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.

When an enquiry was made on the type of information is shared with the community on GBV the following topics were listed:

- 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 processes to follow should they feel that they are being abused.
- Drug awareness.
- Education on HIV/AIDS and its connection to GBV.
- Programmes on parenting.

Interestingly, it was reported in KwaNdengezi that societal and cultural norms dictate what type of information is considered acceptable to be shared within the greater social context and with whom it should be shared.

<theme 1 form>

THEME 2: 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" (Foundation for Human Rights 2020).

This theme focuses on participants' opinion 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 attain justice. Various challenges with the criminal justice are also explored here.

The theme is further sub-divided into the following sub-themes:

Sub-theme 1: Reporting and response

Sub-theme 2: Good outcome for a GBV case

Sub-theme 3: Challenges with the justice system

2.1. REPORTING AND RESPONSE

The first step to accessing justice is disclosing or reporting the incident to someone. Participants cross all sites reported that victims report GBV to various avenues such as the clinic, hospital, church, school but the police are in most cases the first point of contact where reporting of GBV is concerned. It was also emphasised that survivors generally report GBV to individuals they trust, more especially child victims who mainly report to individuals such as teachers, close family members or neighbours. On the other hand, the respondents' replies about trust contradicted their view about the police as the majority reported that they do not trust police officials. When asked for reasons why people do not report incidents of GBV five main reasons were shared across all project sites.

- **Secondary victimisation**

Revealed from all sites was that one of the primary reason why individuals do not report GBV cases, especially to the police, is secondary victimisation. It was reported that re-victimisation mostly takes place through victim blaming or disbelief, insensitivity towards the victim, insensitivity when dealing when members of vulnerable groups such as the children, the elderly, persons living with disabilities and members

of the LGBTQIA+ community, and lack of privacy and confidentiality where statements are taken in front of everyone at 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 Victim's Charter discussed under the literature section. The latter highlights a further issue regarding the lack of or limited use of victim friendly facilities (VFF) at police stations reported by participants at five of the sites (i.e. Mbombela, KwaMashu, Emalahleni, Diepkloof and KwaNdengezi).

> *"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 the 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/SAPS]

> *"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 center there […] we do have a victim friendly room […]."*

> *"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 is a challenge internally at the station is the issue of not having a trauma room where like trauma room that when someone comes, like rape victims, someone who is abused from home be able to, 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 or lack of use of VFFs were lack of knowledge by police officers on how to treat GBV survivors, lack of resources in terms of both equipment and human resource.

> *"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* […]*."*

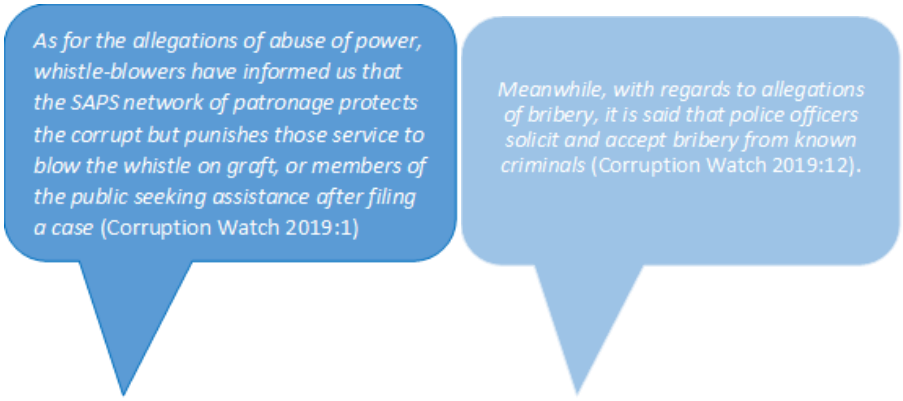
> *"It's fully equipped but human resource wise now, 'cause previously the most of our victim friendly facilities here in Ehlanzeni they were operating 24 hours but now you find that they are operating during the day because we had volunteers before who were there supplied by GRIP. So since GRIP lost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

Important to note is that research participants added that the police are not the only service providers who retraumitise survivors of GBV. In line with available data, it was explained that survivors can also be retraumatised by family members, the community and other service providers dealing with response and prevention of GBV.

- **Lack of trust**

Almost all participants, including police officials, reported that there is little to no trust between community members and the police and in turn survivors of GBV are likely not to report their cases to the police. It was explained that this is attributed to the poor understanding by police officials 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. It was reported that some police officers cannot be trusted since they are friends with perpetrators. Based on the report promulgated 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).



- **Socioeconomic issues**

Connected with existing literature on the topic, this study revealed often women who are victims of GBV, specifically DV, do not report the crime due to being financially dependent on their abusers. It was said that they feel afraid of losing their homes, their ability to pay bills – including food, clothing, school fees and other daily expenses – or fear 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 and 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).

Stats SA (2020) further reports that where gender is concerned more women (n=32.4%) were in Q2 of 2020 affected by unemployment the most in comparison to their male counterparts (n=28.3%). In addition, black African women were in Q2 of 2020 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 are victims of domestic violence do not report their abuse due to financial dependency on their violent partners, who are in most cases men.

Table 5: 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 • Have other reasons for not searching	**2.9M** **0.8M**

<indent source and full ref>Source: Stats SA (2020)

It can thus be resolved that it was found in this study that economic deprivation is linked to VAW. Conversely, only one participant (a worker in KwaZulu-Natal) reported that many professional and educated women also experience IPV but the majority do not report since they need to maintain their social status. Revealed here is that the changing economic status between men and women where women are become emancipated financially is a risk factor for IPV. However, maintaining a social status as a reason for not reporting is a perpetuation of a myth that only certain people are susceptible to GBV.

- **Personal safety**

Reported in KwaNdengezi and Emalahleni was that some victims do not report GBV due to having received threats from either their abusers, families or community. Getting help for DV often increases feelings of fear for victims. They may fear that the abuse will get worse or 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 one takes in whether, or how, to seek help. As previously expounded on, three women in South Africa are killed a day by their abusive partners, so the threat of further harm if one leaves a relationship or seeks help outside of the family, is real.

- **Distance of the police station from the community**

It was discovered in KwaNdengezi and Mbombela that most of the rural communities are discouraged from reporting cases of GBV because their local police stations are 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 coz 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 will be expounded on in more details later in the report under the risk factors theme.

2.2. GOOD OUTCOME OR JUSTICE IN A GBV CASE

When asked what a good outcome of justice for survivors or GBV in the view of the research participants was, it was reported 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 is attained in a GBV case is the survivor receives holistic and integrated support services, which are victim-centred.

> *"It's a holistic approach. If the victim feels that all steps have been following and is treated fairly then the victims 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 but 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."*

Below is a schematic representation of what stakeholders participated in this research study viewed as a good outcome or justice for a GBV case or what victims seek when they report.

Figure 5: Justice in a GBV case

<same pg table>

Interestingly, it was reported only in Alexandra that one of the outcomes a victim is seeking for when reporting a GBV case to the police is to receive a protection order. This then raises a question regarding community's understanding of the purpose of a protection order and/or processes followed to attain it.

When participants were asked what the consequences of not attaining justice for GBV survivors were, it was reported that survivors are 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 end up committing suicide (also refer to the impact of GBV under the literature). It was also explained that in the case where the violence continues, some victims end up normalising the abuse while others or the community decide to take the law into their own hands through acts such as vigilantism also referred to as "mob justice" by study participants. Mob justice takes place when the community attacks a person suspected of a criminal act with stones, clubs, machetes and varying other weapons. It was highlighted that mob justice is often caused by varying failures in the justice system such as corruption, poor laws and wanting justice instantly.

2.3. Challenges with the justice system

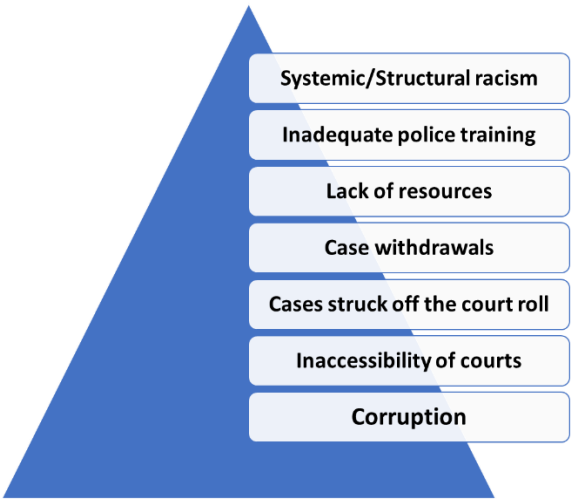
The next pair of questions on access to justice were centred on the challenges experienced with the justice and what can be done to improve justice. In their responses, participants focused exclusively on the police and the court. Some of the challenges raised as participants under this theme were also raised in previous theme and were discussed exhaustively. As a result, to avoid repetition in this section we will focus on issues which were not previously deliberated on such as systemic racism, poor police visibility, cases being struck off the court roll, cases taking too long to finalise, language barrier, courts being inaccessible.

- **Systemic racism**

What one participant in KwaNdengezi pointed out as one of the main problems with the justice system is systemic racism, which was said to be linked to the delivery of poor-quality services mostly in communities (such as in rural areas and townships) where the great majority of inhabitants are black people. Johnson quoted by the Yancey-Bragg (2020) defines systemic, institutional or structural racism as "systems and structures that have procedures or processes that disadvantage [people of colour or Africans]." Explained by the stakeholder who raised the issue of structural racism in KwaNdengezi is that the justice system that serves the rich, who are mainly white (living in urban areas) is not the same as the one that serves the poor in rural and peri-urban areas. He postulated serves the rich and not the poor and thus structural racism or class issues play a significant contribution in 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/Health Care]

Figure 6: Challenges with the justice system in the community



In connection to structural racism, two participants (one from KwaNdengezi and another from Diepkloof) representing a CBO and an NPO argued that some of the problems experienced with the justice system in their communities could be attributed to **language as a barrier**. It was explained that as much as police officers are 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 exacerbates the problem. Moreover, it was explained that it is also not easy for survivors to tell their stories or for witnesses to testify in court in a "foreign language".

> *"The number 1 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 then raises a concern regarding the utilisation of interpreters in court. Court interpreters play a critical role in the administration of justice by making sure 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, plays a role to interpret 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).

- **Cases struck off the court roll**

Mentioned in KwaNdengezi and Mbombela as one of the challenges the community experiences with the justice system is the many GBV cases which are purported to be struck off the court roll. When queried on why cases are struck off the roll stakeholders pointed out poor investigation and lack of evidence as two of the primary reasons. Added was that due to poor investigation some cases do not reach the court.

Further mentioned as a point of contention with the court at the same sites is the number of **cases being withdrawn by the court** and the same reasons cited above were cited here as well.

> *"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 summon, 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/SAPS]

Further mentioned as a challenge was poor communication by Investigating Officers (IO), which causes frustration to victims as they are not regularly informed on the status of their cases. Refer to the Victim's Charter focused previously for victims' rights.

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

Regarding the issue of finalising cases reported as a challenge in Mbombela and KwaMashu, it was in the same breath by the stakeholders who mentioned this challenge that the introduction of the sexual offences courts is to a certain extent speeding up the process of finalisaing sexual offence cases.

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

> *"We also have two sexual offences court* [here in Ntuzuma Magistrate Court] *which are well equipped, they have all the resources. The sexual offences courts started in* 2013 […]." [Statutory Service Provider]

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 also highlighted some challenges experienced by the sexual offences court one of which is the "inherent interdependence in the criminal justice system that often cause serious delays in the finalization of cases" (Heath, Artz, Odayan & Gihwala 2018:10). This was also found in this current study and 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 Social Worker]

The final challenge under the court in the communities is the inaccessibility of courts. It was 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 is inaccessible to people living with disabilities as it does not have a wheelchair ramp. It was found that what furthers the inaccessibility to the courts is the non-attendance of community awareness campaigns by court officials. It is for this reason that stakeholders felt that most members of the community do not understand how the criminal justice functions as the information is not cascaded.

Mentioned only in Alexandra were issues with the Domestic Violence Act. Fortunately, in March 2020 the Department of Justice and Correctional Services opened a call for submissions on the Domestic Violence Amendment Draft Bill, 2020 of which the purpose is to amend the DVA, 1998 in the following ways:

- Further regulation of certain definitions;
- Additional facilitation for obtaining of protection orders 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 (Department of Justice and Correctional Services 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 and Saartie Baartman, Centre for Women and Children; and Obstetrics & Gynaecology Education, UCT in the field made a joint submission.

SAPS National Instructions

With the above challenges in mind, six law enforcement officials (i.e. SAPS, CSL) were asked specific questions relating to the availability of national instructions that provide guidelines on how to handle the various types of GBV. Important to note that not all police officials who were part of the study were asked these questions, these specific questions were developed during the course of the research as issues relating to the lack of police training in dealing with GBV arose. Of the six participants who answered this question, they reported the availability of national instructions at police stations.

> *"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 that 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 about the nature of the incidence. And then again we've got also is it SAPS 508? 508 in a case where the victim of domestic violence came to the station after hours the court is 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 508 A, 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 of 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* […]." [Statutory Stakeholder/SAPS]

Conversely, it was stated that the availability of the national instructions at the stations does not mean that all of the police officials are aware that there are such 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/SAPS]

When participants were asked are able to both interpret and apply the national instructions, it was consistently reported that many police officials, especially at station level, do 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/SAPS]

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

> *"We receive FCS course. I think it's 2 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/SAPS]*l]*

> *"We do domestic violence training and then eeeeeeeerrrr… 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/SAPS]

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

When the members of the SAPS were probed on what they would you like the community to change to make their job easier in relation to dealing with domestic violence or sexual offences cases, two main responses were provided:

- Community should stop stigmatising gender minority survivors of GBV.
- Community members could change their negative attitude towards the police; be more understanding of the investigation procedures that need to be followed where cases of DV or sexual offenders are concerned.

Overall, it can be said that 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. Of concern is the length of training offered to officials working in special units such as the DV unit where a training of only a one week on GBV related issues is not enough.

<theme 1 form>

THEME 3: GBV RISK FACTORS

Risk factors were determined through the use of the ecological model which presents causes at the individual, family, community and society level.

This theme is further into the following sub-themes:

Sub-theme 1: Causes of GBV

Sub-theme: Types of GBV committed in the community

Sub-theme 2: Issues affecting vulnerable group

3.1. 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 cause violence, but that rather a combination of multiple risk factors are associated with criminal behaviour. GBV risk factors in this study are explained using the ecological model of factors associated with gender-based violence by Heise (1998). Important to note is that the model was in this study slightly modified in terms of schematic presentation. The ecological model presents GBV risk factors at the individual level combined with risk factors within the family, the community and the society at large.

Figure 7: GBV Risk Factors

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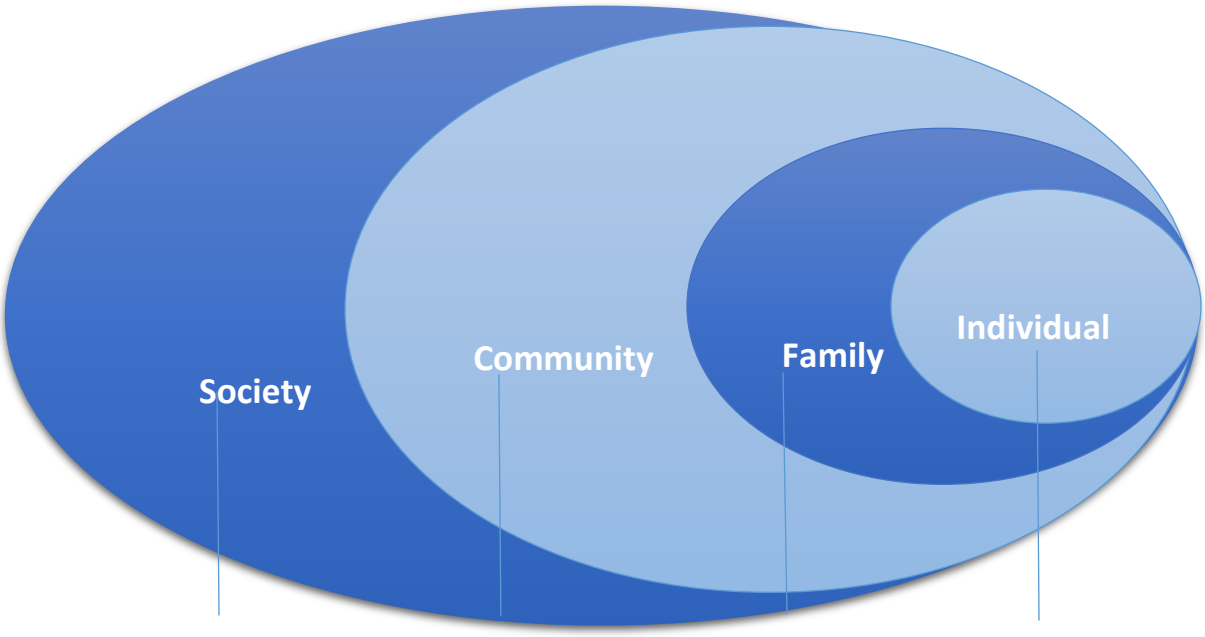

Harmful social norms	Poverty, unemployment, and lack of education, substance abuse, overpopulation, environmental design, normalisation of GBV	Financial dependency on abuser, substance abuse	Witnessing violence as a child

Adapted from: Heise (1998) <full ref>

3.1.1. Individual risk factors

As explained by Tremblay and LeMarquan (2001), individual risk factors are made up of one'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 found to be as risk factors for GBV: witnessing conflict between parents during childhood, being abused as a child, having an absent father, and substance abuse.

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> *"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 cares 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*[13] [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 Stakehoder]

The above excerpts confirm the central message of the Social Learning Theory [SLT] (1971) by Albert Bandura 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 purely in three ways, namely, observation, imitation and modeling (Bandura 1971). Additional to learning through observation, learning also takes place through observation of rewards and punishment or a process called vicarious reinforcement or vicarious punishment (Bandura 1971). This simply 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.

3.1.2. Family risk factors

Research on the causes of childhood offending as well as adult criminality often points family influences as one of the main causes of antisocial behaviour (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 some of predictors of a

[13] The Okapi is a lockback or slip joint knife.

pathway to criminality. Family is the first institution of socialistion, therefore if one fails to form positivite domestic relationships or develop positive attitudes from one's interaction with family members, the likelihood of following a criminal pathway is increased. 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 they also want to have life as well* […]*."* [Statutory Stakeholder/Municipality]

> *"* […] *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 one to develop violent behavior.

3.1.3. 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 are too many taverns in the community and that most of tavern owners do not abide by the Liquor Act, 2003 (No. 53 of 2003), hereinafter referred to as the LA, as well as the provincial Liquor Acts which regulate the operations of taverns. It was said that LA contraventions by taverns or *shebeens* range from operating illegally without a license, not obeying operating hours and/or selling alcohol to underage children. Participants were particularly concerned about the many taverns in the community which meant the increase of the amount of alcohol at the disposal of community members. Consonant to previous research studies on GBV, participants in this study held the opinion that there is a strong positive association between alcohol and IPV. As a result, the increased number of taverns in communities were said to contribute to the abuse of alcohol which in turn causes DV, particularly IPV, and other types of GBV such a 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 licenses if 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 Liquor Board. And they can lose their licenses. [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 at the end of the day 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/SAPS Officials]*

> *"[…] 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 drank alcohol, you find a lot of noise, they start fighting."*

Further mentioned as one of the causes of GBV was the abuse of other substances such as marijuana, and woonga or *nyaope*[14]. What stood out from the KwaZulu-Natal sites is a concoction reported to be abused mainly by school children or the youth called *incika*. *Incika* was explained as a mixture of Sparletta soft drink or Sprite with a cough syrup, specifically Codeine[15]. Another substances which were said to be abused mainly in KwaMashu and KwaNdengezi are antidepressants such as Xanax[16].

> *"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 they [saw music artists drinking it]*

[14]*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.
[15] The following are some of the side effects of codeine: drowsiness, dizziness, lightheadedness, nausea, shortness of breath, stomach pain, sweating (Cunha 2020).
[16] Xanax is used to treat panic and anxiety disorders. Health online explains that people who take Xanax for recreation purposes experience a sedating or calm feeling (Drugs.com 2020).

> *because 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 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]

Pertinent issues are highlighted in the verbatim responses by one of the stakeholders from KwaZulu-Natal. Firstly, it is revealed that children in the community start abusing substances from a very young age, during their primary schooling years. Secondly, that due to being high on substances, children engage in risky behaviours such as train surfing as well has having unprotected sex with each other. Further metioned in KwaMashu was the issue of over grown shrubs around the schools as a hiding spot used by school children to engage in sexual intercourse with each other. Thirdly, the association between being high on drugs and contracting sexually transmitted infections (STIs) and HIV/AIDS was highlighted by this respondent as well as in the literature. Fifthly, due to community risk factors such as the abuse of substances children start committing GBV, such as rape, at a very young age. Lastly, 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 possibly means that community members are starting to 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 five of the six sites, with an exception of Alexandra, as a source of heightened stress, which leads to GBV. rates in all project sites which have been highlighted throughout the reports as part of the reasons why victims are financially dependent on their abusers. Reported only in Emalahleni and KwaNdengezi is the issue of parent mortality which make orphans vulnerable to abuse. A connection was made between the latter and the grooming and sexual abuse of young girls by elder men, such as taxi drivers, which will be discussed under the next sub-theme. Further reported in Alexandra, KwaMashu and KwaNdengezi was the normalisation of resolving issues through violence as a community risk factor.

Reported only in KwaMashu was the issue of spatial injustice (i.e. lack of proper infrastructure) as contributing factors towards the high levels of GBV in the community. Spatial injustice involves the unfair and unequal distribution of space 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).
> <all quote similarity check>

In this research study, the lack of recreational facilities in the community and schools which are not conducive to learning were pointed out in KwaMashu as some of the reasons why children often meander aimlessly on the streets and thus end up engaging in destructive behaviours such as abusing alcohol and other substances.

> *"*[…] *there are no proper sport 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 then 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 due to the fact that services provided do not increase with the growth in population and in turn many victims of GBV do not receive the necessary support and care they require. Moreover, it was explained that Alexandra is not a permanent resident for many people and most 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. As a result, once one finds his/her stable place of work or to live in 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) which hypothesises that poverty, ethnic heterogeneity and residential mobility lead to social disorganisation, which in turn affects informal social control to crime and thus increases criminal

subculture. Informal social controls are reactions by a group that enforce conformity to norms and laws in turn 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 values of what is considered lawful or unlawful informal social control of crime are weakened. As a result, an absence of stable or common standards and a breakdown in community institutions result to failure in the effective socialisation of children (Shaw & McKay in Coleman & Norris 2000:57). Likewise, residential mobility or the rapidly changing population increases anonymity between community members. As such, the increased level of anonymity makes it difficult for community members to discern if there is a criminal among them. The issue of residential mobility was also highlighted as a risk factor in KwaMashu especially where the hostel and informal settlements are concerned.

3.1.4. Social risk factors

Found in this study and in line with other research on the topic, was that GBV problems in their communities are a reflection of the broader societal issues. It was acknowledged at all sites that the societal battle with patriarchy where men hold the power and women and children are viewed as subordinates to men was one of the biggest causes of GBV. As previously explained, harmful social or traditional norms play a significant role in the cause and perpetuation of GBV. There are beliefs or sayings in the African tradition which research participants have reported 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 through a coffin"); "*Monna ke tlhogo ya lapa*" ("A man is the head of the family"). Such beliefs, to a certain extent, encourage the abuse of many married women and make it difficult to seek help from either family or the CJS. Those who seek help from family are often pressured to stay (often for the sake of the children), to 'work it out', to not 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 for preventing further violence. Furthermore, sometimes people have reported domestic violence to the police, the courts, social workers or family and friends, and have not received the assistance that they needed – for example, reporting to the police and being told that there is nothing they can do because it is "a family matter". The latter was said to be attributed to the belief that one should not hang their dirty laundry in public.

There are also traditional beliefs that define what it is that makes one 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 subordination of women to men and the multiplicity of masculinities where some form 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 such as 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 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..." (Ratele 2016:9).

> *"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."*

In addition, over and above the negative effect toxic masculinities or harmful social 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 to the lack of GBV reporting by cisgender heterosexual men who 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 because they are, based on the hegemony of masculinity, being "corrected' and they experience revictimisation when they report by being scolded for not being "men enough".

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

- ✓ Abuse of drugs and alcohol
- ✓ High levels of unemployment
- ✓ Harmful cultural/social norms

Interestingly, unemployment was not reported only in Deipkloof as a risk factor.

3.2. TYPES OF GBV

It was unanimously reported across all six sites that the most prevalent type of GBV experienced in the communities is domestic violence (DV). Moreover, when participants were ask which group of people is mainly victimised, it was iterated at all sites that women and children are more at risk. This is in agreement with both the SAPS statistics as well as previous studies done of the topic discussed earlier on. In the same way, when participants were probed on which group of people are often perpetrators of GBV, they

expressed that men were more likely to commit GBV than women. Nonetheless, some respondents also cautioned that they did not imply that men can never be victims of GBV or that women do not commit GBV.

> *"We don't seem to have an honest and frank discussions about the causes, the root causes of gender-based violence, instead there's that 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 pus you over the edge."* [Statutory Stakeholder/Health Care]

The main types of domestic violence reported by the majority of stakeholders was IPV in the form of physical, sexual or emotional and financial abuse perpetrated mostly by men on woman. It was additionally reported that physical violence also often takes place between other members of the family other than intimate partners. The over consumption of alcohol was shared as a contributing factor to the latter. Children were said to also be abused within the domestic setting both physically and sexually. Male members of the family such as fathers, step-fathers, brothers and uncles, for example, were said to be the ones responsible for the sexual abuse or incest of mostly girl children. Of biggest concern, is the fact that participants across all project sites revealed that abusers are in most cases the only breadwinners in the family are often protected by not reporting GBV cases. The family would thus rather sacrifice the child's well-being by not reporting the abuse in order to prevent loss of livelihood. It was further reported that in other cases where the perpetrator is a member of the community he/she is 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. What is worrying, is 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 maltreatmed as defined previously by WHO (2020). It was explained by the research participants that mothers, especially teenage mothers, drug their children and leave them on their own on weekends in order to go partying.

> *"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."*

Where GBV outside the domestic context is concerned incidents of rape (by perpetrators who are both known and unknown to the victims) were reported as the highest followed by physical assaults. Alcohol was once again said to play a huge role in assault incidents. Moreover, spiking of girls' alcoholic drinks at parties by boys who in turn 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]

Reported in only two sites, namely, Diepkloof and KwaNdengezi is the sexual grooming of school girls by elder men, more especially taxi drivers or scholar transport drivers.

> *"So they would be sexually grooming the girl, buying them present.* […] *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 Social Worker]

> *"*[…] *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 down, 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. It was said that after campaigns some victims do 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 Social Worker]

Still on the issue of taxi drivers, one participant in Emalahleni pointed out that women are generally not safe when using public transport, particularly taxis. The stakeholder also explained that each local taxi association has 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 do not reach the committee because the public is not aware that there is such a structure in place. The below word-for-word response provides an example of how taxi drives 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 the Gauteng and Western Cape provinces highlighted sexual harassment, verbal harassment and visual harassment as the type of GBV crimes committed against women who use taxis as a mode of transport. Found in this study was that sexual abuse perpetrated by women while using taxis included rape, masturbation and inappropriate touching while visual abuse included leering and starring at women inappropriately and verbal harassment included shouting and using inappropriate language by taxi drivers and other passengers (Mabaso 2019).

Reported only in KwaNdengezi by one stakeholder related a story of a young girl who was a victim of *ukuthwala* (in IsiXhosa) or *ukuganisela* (in IsiZulu), "a form of forced marriage whereby a girls' parents open [*ilobolo*] [17]negotiations with a boy's parents" without the girl's consent (Mtshali 2014:51).

In addition, it was revealed that in communities such as Shongeni and Zwelibovu in KwaNdengezi families give their girl children up to marriage as they believe that marrying them off will make things better for their poverty-stricken families.

3.3. ISSUES AFFECTING VULNERABLE GROUPS

When participants were asked if services provided for GBV victimisation of vulnerable people, the general response was "NO!". When asked which type of crimes are mostly committed against vulnerable groups in their communities answers ranged from child abuse (physical, sexual and neglect) as previously mentioned, rape and neglect of children and adults living with disabilities, neglect and financial abuse of the elderly to

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

verbal and physical violence, and corrective rape against members of the LGBTQIA+ community. Mentioned only from two sites, KwaMashu and Emalahleni, was the killing of people living with albinism, for the purpose of harvesting their body parts for *muti*[18].

Issues relating to children were discussed extensively in the previous sub-themes. When stakeholders who participated in this research were asked, if in their communities, needs of child victims of GBV are catered for most explained that even though they are catered for services meant specifically for them are not enough. However, it was explained that in a case of GBV involving children – children's' needs are always put first.

> *"No they* [shelters] *are not* [enough]*, that's the main issue because they are not. Because sometimes when you call SAHARA[19] 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 were can, firstly remove children and then we try and figure out that 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/Social Worker]

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 living with disabilities. In KwaMashu two organisations for people living with disabilities where one focuses mainly on children and the other focuses on both children and adults are part of the project. The stakeholder whose focus in mainly on people living with mental health disabilities had the following to say about 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 organisatiion 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 number of people because we are an NGO."* [NPO Social Worker]

[18] *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.
[19] SAHARA is a shelter for abused women and children situated in Phoenix, North of Durban.

The participant further explained that their residential facility houses up to 65 victims living with mental health disabilities of all genders who are between the ages of 17 and 55. When asked what happens to victims who need a place of safety but do not fall within the above age range it was explained that they are 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 learn manual skills or "how to work with their hands". When the stakeholder was asked what in her opinion are the reasons why people living with mental disabilities are abused; she explained that perpetrators take advantage of the fact that they cannot easily express themselves or explain what has happened. Nevertheless, the respondent added that it is not common for a person living 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 who are living 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 as our challenges as our organisation."* [NPO Social Worker]

Another respondent who represented an organisation (still in its infant stand and not yet formalised) for people living with disabilities explained that their primary focus is to support parents of children living with various forms disabilities.

> *"Our group works with parents of* [children living 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 living with disabilities. That is how I was introduced. We sort of realised that* [that organisation] *dealt with the children or* [people living with disabilities] *and then the parents were left out. And they kind of – 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]

Highlighted in the above excerpt are two factors: (1) The lack of knowledge by parents on the type of disabilities their children are living with; (2) The lack of support to parents with children living with disabilities. The participant further highlighted that these factors contribute to the neglect of children living with disabilities by their parents. When the stakeholder was prodded to expand more on what the term 'neglect' meant 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 are denied their basic rights such as family care and parental care, basic nutrition, basic health care, education, and social care and protection. The respondent further illustrated that due to neglect by parents most of children living with disabilities do not go to schools or stimulation centres; some do not receive a disability social security grant and others lack assistive devices such as mobility (i.e. wheelchairs, crutches, etc.) and hearing aids, for example. Another type of neglect was said to leave children in the care of people who do not know how to look after a child living with a disability. It was stressed that this increases the likelihood for victimisation of the vulnerable child (i.e. rape).

> *"Mainly rape. Rape of the child* [living 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 live 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]

On the other hand, it was explained that parents with children living with disabilities face a lot of challenges related to access of services for their children and thus many of them end up giving up. The stakeholder explained how frustrating it is just to apply for a disability grant or to request for an assistive device. She said they are often sent from pillar to post and what makes the process even harder is the fact that the child is expected to always be present which was said to be very difficult as most parents make use of public transport with ac child who must be carried, in a case of a physical disability, while an application for an assistive device is underway.

> *"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 wheel chair. 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 SASA they say go to 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 faceThe 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 assistant 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 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 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]

Last point regarding services being difficult to access, the stakeholder underscored that some of the buildings where services are offered are inaccessible for people living with disabilities, especially physical types of disabilities, as they do not have ramps for wheelchairs, for example.

> *"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]

Based on another stakeholder who also represented an organisation that offered service to people living with disabilities – differently able peopled are overlooked where GBV response and tailor-made prevention programmes are concerned.

> *"When it comes to …* [inaudible] *people still hide away their* [family] *members that are disabled and we are unable to reach out. The only times we find out about vulnerable people is when it comes to applying grants. When it comes to LGBTQ matters, this vulnerable group has become a lot more vocal about supporting and raising matters within the community. When it comes to the elderly and disabled, I think there is not enough being done in the community for them."*

The above excerpt then leads us to a discussion of issues relating to two groups of vulnerable individuals, namely, the elderly and the LGBTQIA+ community, who are also often victims of GBV. Where the elderly are concerned, it was highlighted in KwaNdengezi that 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. It was said that grandchildren meant to care for their grandparents are often the perpetrators.

Participants from all sites admitted that their communities still lack knowledge about issues affecting members of the LFBTQIA+ community as well as their specific needs. Found in this study from all six sites was that members of the LGBTQIA+ were often verbally abused or called names and, were victims of corrective rape, more especially lesbians. An example of a popular South African derogatory term used

to refer to homosexuals is *'stabane'.* Where curative and 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. In addition, perpetrators report that actions of men who commit rape against lesbians "who try to be like men" are justified since they are defending the authenticity of men (Naidoo 2018).

The last vulnerable group mentioned only in KwaMashu and Emalahleni are people who live with albinism. It was discussed that people living with albinism were murdered for harvesting of their body parts for muti purposes, as it is believed that their body parts 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 living 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, 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 living with albinism to the traditional healer (Mabona 2019). In KwaMashu, one participant narrated of a story of a father who was asked by a traditional healer to sell his child living 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 father must sell him his daughter, he wants her hair and her eye, hair was maybe 2 thousand and an eye also will be 2 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 are very few stakeholders in the project sites focusing solely on the vulnerable groups, it was explained by the statutory service providers that their services cater for all members of the community including the vulnerable groups. Further mentioned by statutory stakeholders was that 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.

<theme 1 form>

THEME 4: SUPPORT STRUCTURES

This theme covers services put in place to support individuals in the network doing work on GBV related issues.

This theme is further into the following sub-themes:

4.1 Masiphephe Collaborative Network

4.2 Referrals and follow-up

4.3 Trauma and skills

4.1. MASIPHEPHE COMMUNITY COLLABORATIVE NETWORK

This section covers participants' perception of Masiphephe regarding its goal, whether they have been part of a similar network before and what in their opinion will contribute to the success or the failure of the network. The majority of participants reported that they have never been part of a network like Masiphephe before. When the few who mentioned having been part of similar projects before were probed on similarities and differences between the projects, it was reported 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, what was picked up from most of the participants is the lack of ownership of the project as most held the opinion that Masiphephe "belonged" to USAID, CCI, GHJRU and 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 in order to make referrals and follow-up easy.
- Encourage a GBV prevention approach that is people centered.
- Unite various stakeholders working with GBV issues in order to reduce GBV.
- Advocate and to empower victims of GBV.
- Ensure that stakeholders operate effectively.
- Educate the community about issues of GBV.

When participants were asked what their expected outcomes from the project are 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 are 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.
- Not working towards a common goal or 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.
- Stakeholders working together and supporting each other.
- Allowing the community to share their ideas about how they think their problems could be resolved (bottom up approach).

4.2. REFERRALS AND FOLLOW-UP

Found in all project sites was that the statutory departments and a few established civil society organisations had formal referral systems in place while the overwhelming majority of stakeholders had no formal referral systems. Even though statutory departments had referral systems in place, it was reported that because each department has its own referral management system that can cause duplication of services as survivors are sometimes referred to more than one stakeholder for the same service. The importance of having an effective referral management referral system in place cannot be emphasised enough. A referral management system plays a vital role victim empowerment as it helps to keep track of the survivors' referral 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.

Similarly 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 monthly feedback is provided; following up with the service provider to which the survivor has been referred; providing follow-up services or the survivor; or visiting the survivor at home. Participants from TCCs and DSD reported that they are able to effectively follow-up on their cases since survivors are offered 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 refer survivors of GBV to other services such as spiritual counselling or traditional healing, the great majority that it is not within their discretion as professionals to refer to such services. It was explained that the victims based on their faith and belief seek such services independently. When asked if there is a formal network of pastors or traditional leaders and healers the stakeholders work with, the general response was "No!" Based on this discussion, it is clear that stakeholders in this project were not likely to explore alternative pathways to justice outside the formal justice.

4.3. TRAUMA AND SKILLS

The study revealed that service providers working with GBV were highly susceptible to and experience secondary trauma. Statutory service providers reported that their organisations have psychosocial support systems in place 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, it was also reported that support services for dealing with trauma and burnout are not compulsory or are either not

easily accessible, thus some participants opt to not use the services or to use services such as informal debriefing with a colleague over a cup of coffee. While statutory service providers reported having access to psychosocial, a considerable number of participants who work for CBOs and NPOs reported not having access to any trauma and burnout services. When participants how they deal with the trauma from the work they do various approaches such as prayer, meditation, speaking with friends and family, being counselled by a pastor were mentioned.

When respondents were requested to share what their training and needs skills were or the skills required for one to effectively deal with GBV cases are, the following suggestions were made:

SAPS

- Statement taking for members of the SAPS especially those station level.
- Intense domestic violence 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
- Handling cases of the vulnerable groups.

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 are already doing work on GBV issues but they do 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.
- Handling cases of the vulnerable groups.

Health care professionals (forensic nurses and Drs)

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

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

5. RECCOMENDATIONS

ALL STAKEHOLDERS

- **Promote collaboration among stakeholders responding to and preventing GBV**

It has been recognised that response to and prevention of GBV is not the work of only one department (i.e. the SAPS), as such a multi-sectoral coordination is pivotal. Even though the government can manage social risks, very little can be done without coordination of response and prevention efforts at the local level. Important to note is that 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 (2020), in order for coalitions to be successful, they need to ensure the following:

- ✓ A collaboration must have clearly defined, manageable an focused goals;
- ✓ Must have adequate time to plan.
- ✓ Collaborations should be evidence-led where response and prevention approaches are based on research data on what needs to change in the community.
- ✓ Implement prevention policies and programmes that have been tested and proven effective.
- ✓ Ensure implementation quality 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.

- **GBV and victim empowerment (EV) training**

To enhance stakeholders' knowledge of issues relating to GBV, it is recommended that foundational courses on GBV be offered to stakeholders, more especially NPOs and CBOs. In addition to the latter, training on VE needs to be offered to all the stakeholders (statutory and non-statutory). Moreover, development of victim-centred response and prevention efforts (by all stakeholders) cannot be emphasised enough.

The following are the benefits of victim empowerment as highlighted by Nel and Van Wyk (2013).

- ✓ Reduces shot and long term PTSD;
- ✓ Minimises poor concentration and prevents social withdrawal by victims;
- ✓ Facilitates victim's recovery by identifying and treating victims' feelings of depressions and shame; and
- ✓ Assists victims to recognise and report the physical impact and symptoms of victimisation (i.e. headaches, diarrhoea, stomachache, etc.).

- **Challenging social/cultural norms**

While there are many causes to GBV, one of the most common social risk factor identified at all six sites is harmful social/cultural norms. It is therefore, recommended for efforts that challenge cultural and social norms that support violence to be developed. Examples of such programmes are as follows: provided by are as follows:

- ✓ Community dialogues targeting all members of the community with the aim of correcting misperceptions people have and attitudes towards others. The community to work together in replacing harmful social or cultural norms with new and healthy cultural norms. Moreover, these dialogues should need to further focus on helping boys and men to develop masculine identifies that are healthy and non-violent.
- ✓ Programmes targeting IPV and youth violence aiming to reduce dating violence among teenagers and young adults through the challenging of 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 make violence behavior an offence to be emphasised (WHO 2009).
- ✓ 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.

A list of examples of harmful social norms is attached as Annexure C at the end of the report.

Other recommendations

- Provide of 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 a local monitoring and evaluation tools applied by all stakeholders to assess GBV preventative 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, find out what services are available in the community and create a referral directory.
- Encourage communities to develop informal social controls of GBV alighned first to the law and an integrated system applied by all stakeholders responding to and preventing GBV.
- Thobane (2015:166) reccomends that "to 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."

CRIMINAL JUSTICE

- Make appropriate resources available to CJ role-payers. Furthermore, 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 criminal justice officials on how to deal with cases of GBV and how to offer victim-centered 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 taking 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.
- Create a centralised and multi-user case tracking system that can link various statutory departments such as the police, health, court where all stakeholders can receive updated information on the status of a specific case.

DEPARTMENT OF SOCIAL DEVELOPMENT

- **Parenting skills classes**

As shown in this study, poor parenting is one of the family risk factors attributed to the development of violent behavior. As a result, supporting parents through parenting skills courses can be considered one of the critical approaches to prevention and reduction of GBV. As explained by Thobane (2014:208) "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." Moreover, 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. Explained by Gould and Ward (2015) is 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 parenting (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, except in Diepkloof, as one of the community risk factors for violence, parental 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. In Section 114, it is highlighted that capacity building of parents ought to act in the best interest of their children by (Gould & Ward 2016):

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

The Integrated Programme of Action Addressing Violence Against Women and Children [2013-2018] (POA:VAWC) addresses poor parenting skills as one of the root causes of violence and thus focuses on strengthening early intervention approaches that focus on the early identification of high-risk children (i.e. truancy) and families (i.e. overconsumption of alcohol by parent/s). The POA provides comprehensive, multi-sectoral and long-term strategic approaches that prevent VAWC.

As explained by Ward and Wessels (n.d.), children whose needs are met during the early years of their lives succeed at school, they have good relationships with others and they, in the end, become productive adult members of the society. Parenting courses where parents acquire skills such as giving clear instructions, exploring other non-violent methods of discipline (i.e. time-out) instead of spanking and enhancing the parent-child relationship yield good results. Therefore, banning corporal punishment in the home on 18 September 2019 by the Constitutional Court of South Africa was a step in the right direction.

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.

COMMUNITY; SOUTH AFRICAN NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE (SANCA); SAPS; DEPARTMENT OF BASIC EDUCATION (DBoE); AND MEDIA

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

Overconsumption or abuse of alcohol and other substances was mentioned various times from all project sites as one of the biggest contributors to GBV. In addition, underage drinking and drug abuse was reported as one 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 (2011) 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 the change of the environment (Fagan et al 2011). Furthermore, the programmes focus on decreasing risk factors (listed below) and elevating alcohol use protective factors (Fagan et al 2011).

Multiple risk factors that increase the likelihood of alcohol use among have been identified from various research on the topic as follows (Fagan, Hawkins & Catalano 2011):

- ✓ 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:

School based curricula: The DBoE 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 offers refusal skills, encourage parent/child communication about alcohol use through homework (Fagan et al 2011).

Environmentally focused strategies: As explained by Fagan et al (2011), 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, there also needs to be an increase in the application of polices and laws on alcohol use or liquor outlet operations where those that do not comply with the law must face consequences (Fagan et al 2011). Currently this is responsibility of the SAPS. However, members community 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.

Awareness and prevention campaigns: More awareness and prevention campaigns on the abuse and other substances to be conducted in the community as well as in schools. Social media and other forms of media could be used in order to spread the message wider and faster.

An organisation that should play a lead role where the issue of the abuse of alcohol and other substances is SANCA. SANCA already runs community development programmes in rural and peri-urban area and has adopted the Community Anti-Drug Coalitions of America (CADCA).[20] Therefore, it is recommended that the seven coalitions in rural and peri-urban areas by SANCA 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 the network. Other stakeholders that focus on the abuse of alcohol and substances should also be recruited.

GLOSSARY OF TERMS AND DEFINITIONS

<relocate and operationalise>

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.

GBV, therefore, 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. Important to note is that the term GBV does not

[20] 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. Available at: https://www.recoverymonth.gov/organizations-programs/community-anti-drug-coalitions-america-cadca.

mean woman abuse, the latter 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).

- **Domestic violence (DV)**

The Domestic Violence Act, No. 116 of 1998, hereinafter referred to as the DVA, 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 1: 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 and the like.
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 or not conversation ensues); 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 damaging 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 (1998) <new Amendment Bill update>

- **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), hereinafter referred to as the SOAA, defines sexual offences as sexual activities, which one has not given consent to, 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 offence.

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

- ✓ **Rape** refers to sexual penetration of the genital organs including 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 living 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 to one another or are from the same immediate family.
- ✓ **Child pornography** occurs when a child is used for publishing pornographic material.
- ✓ **Child prostitution** when one forces a child or a person living 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 as a result of GBV. A survivor is a person who is in the process of overcoming the harmful impact of GBV. For the purpose of 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 perpetrator 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 2: 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 an 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 force marriages. Often occurs among child marriages but can also take place between unmarried adolescents and 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 of 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) 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:

> Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry related violence, marital rape, female genital mutilation and other traditional practices harmful to women, nonspousal 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 (United Nations 1993).

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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ANNEXURE A: Interview guide

Strengthening Local Governance to Improve Gender Based Violence Response the Gender, Health & Justice Research Unit, University of Cape Town

IN-DEPTH INTERVIEW GUIDE

Introduction

Thank you for agreeing to talk to me for this research study on gender-based violence in the communities. My name is _____, I work at the Gender, Health and Justice Research Unit (GHJRU) at the University of Cape Town, and I am one of the main researchers of this project. We ask you to reflect on your professional experience in answering the following questions.

Note to interviewer: We have 6 keys questions and a series of sub questions or prompts.

Your organisation

1. Please tell me about your organisation and what you do? What you do relating to helping with GBV issues or engaging with GBV issues

    - *What is your interest in or connection to GBV?*
    - *What role does your organisation play in GBV (for example, victim empowerment, court preparation)?*

Local GBV networks

2. Tell me more about the challenges with GBV in your community and how you work with other stakeholders to deal with these issues?

    - *What are the challenges and barriers for you to your activities in relation to GBV in your community?*
    - *Where are the gaps in GBV prevention and response in your area? What are the strengths of GBV response and support in your area*
    - *What challenges are there to coordination of GBV prevention and response efforts?*

Community experiences

3. What are the main GBV problems in this community and what services are available to the survivors of GBV and their families?

    - *What types of information is available to the community on GBV?*
    - *How do the community find out about support services and GBV issues- outreach, radio, schools, churches, clinics, anywhere else?*
    - *What about issues affecting specific vulnerable groups such as children, LGBTI community, persons with disabilities (physical, mental and intellectual) and older persons?*

Referrals and victim support

4. Tell me about the services that are offered to survivors of GBV in your community and their families – how are they referred to these services?
    - *Services relating to counselling support or other types of healing support like spiritual guidance or traditional healers etc.*
    - *How do you know how the referrals or support services helped the survivor? Is there a system to follow-up with them?*
    - *Are the referrals or services effective?*

Reporting and response

5. Are their challenges relating to reporting of GBV crimes in your community? If so what are they and how do you think we can improve GBV survivors and the community's confidence in reporting?

    - *Why do people not report incidents of GBV?*
    - *If people do report GBV, who do they report to? Police? Hospitals? Teachers? Social workers? Church? Community Policing Forum?*

Access to Justice

6. How would you define a "good outcome" for a GBV survivor in your community? Is it only formal criminal justice or are there other ways in which survivors get healing and 'justice'?

    - *What are the challenges with the formal justice system in your area?*
    - *How can access to justice and the courts/ police be improved?*
    - *What outcomes do victims seek when they report?*
    - *What happens if victims don't get what they need when they report?*
    - *What does getting justice in a GBV case mean?*

Alexandra Community Collaborative Network

7. What is your understanding of the goals of this project and do you think it will be successful?

    - *Have you been part of other such networks or forums? Have the succeeded or failed?*
    - *What would you like to get from this project – your organisation and also you personally?*
    - *What is different about this project compared to other community projects in Alex?*
    - *What will help it succeed, what will contribute to its failure?*

Trauma and skills:

8. It must be difficult dealing with the trauma of your clients and the community, what type of support do you have for your own secondary trauma doing this work?
9. In this project if you had the chance to do any training or learn any skills or have access to something to help you in your job what would that be?

Ending Q: If you could change anything in the community of Alex to make things improve for women and children there what would it be?

ANNEXURE B: Informed consent form

INFORMED CONSENT FORM – IN-DEPTH INTERVIEWS

Strengthening Local Governance to Improve Gender Based Violence Response

Explanation of the study

This study is conducted by researchers from the Gender, Health and Justice Research Unit at the University of Cape Town (UCT) together with Centre for Communication Impact (CCI). We are interested in factors that contribute to gender-based violence (GBV) and facilitate prevention in this community. We are also interested in the current legal services available and criminal justice system process in the community as well as identifying major points of attrition between GBV reporting and prosecution.

The goal of this project is to reduce vulnerability to GBV through improved local governance and service delivery through strengthening the capacity of local structures to lead, coordinate and manage a community response to GBV prevention.

The Gender, Health and Justice Research Unit has been tasked to interview adult men and women who are involved in the GBV work within the community i.e. service providers, members of the community collaboration network (CCN), practitioners, government stakeholders and community leaders.

Eligibility

You have been asked to participate in this interview if you fit the following criteria:

- You are involved in the GBV work within the community
- You are age 18 or older

Participant rights

If you agree to participate, the interview will last approximately 30 minutes to an hour. We will record this interview. The recording and its transcription will be stored electronically, and they will be accessible only to research staff on this project. Recordings will be destroyed once the transcription has been checked for accuracy. Your participation is completely voluntary – you do not have to participate. If you choose to participate, you may stop the interview at any time. You may choose not to respond to questions, or you can choose to share something off the record. You will not receive any remuneration for participating.

Risks and discomforts

You will only be asked about your perspective based on your professional experience, and will not be asked to share personal information, or provide confidential information about a specific client. You may refuse to answer any question or not take part in a portion of the interview if you feel the question(s) are personal or if talking about them makes you uncomfortable.

Benefits

There will be no direct benefit to you, but your participation may help inform the interventions to strengthened community governance and accountability; to increase primary and secondary GBV prevention, to mitigation of GBV harms (tertiary prevention) and to improve access to justice for all victims and survivors of GBV.

Confidentiality

The information that we collect from this research project will be kept confidential. You will have the choice of being named as the source of the information, or to be anonymised – in which case we will not record your name and the information you provide will not be traced back to you.

Contact details

This project has been approved by UCT's Health Sciences Faculty Human Research Ethics Committee (HREC). If you have further questions about your rights as a research participant, please contact:

HREC, E 52 Room 24
Old Main Building
Groote Schuur Hospital
Observatory
Tel: (021) 406 6338
Fax: (021) 406 6411
or email shuretta.thomas@uct.ac.za.

For more information about the project, please contact:
Professor Lillian Artz
Director: Gender, Health and Justice Research Unit
Tel: 021-406-6023
Email: Lillian.Artz@uct.ac.za

INFORMED CONSENT FORM – IN-DEPTH INTERVIEWS
Strengthening Local Governance to Improve Gender Based Violence Response

Participant statement of agreement

1. The researcher has explained to me that the purpose of this interview is to gather information about factors that contribute to gender-based violence (GBV) and facilitate prevention in this community. They are also gathering information on current legal services available and criminal justice system process in the community.
2. I understand that the questions I will be asked will refer to my own professional work. I understand that I do not have to speak about these practices unless I choose to do so. I understand the overall aims and possible benefits of the research.
3. I understand the overall aims and possible risks and benefits of the research.
4. The researcher has explained that I have the choice to be named as an expert source of information, or to remain anonymous – in which case the information I give will be confidential and my anonymity will be preserved.
5. I understand that I may refuse to participate in the interview, and that I can stop the interview at any point. I further understand that I may refuse to answer questions without having to give any reasons.
6. I understand how the information I give in this interview will be used and how I will be able to learn about the findings of the research project.
7. The researcher has explained the purpose of recording this interview, i.e. to ensure accuracy, and also what will happen to the recording. I agree to the recording under these conditions.
8. I have been offered a copy of this form with contact details of the project coordinator in case I would like further information about the project.

I hereby consent to participate in this research.

1. _____ _____
Signature: Research Participant **Date**

2. _____ _____
Signature: Researcher **Date**

ANNEXURE C: Cultural and social norms supporting violence

BOX 1

Cultural and social norms supporting different types of violence

Child maltreatment

- Female children are valued less in society than males (e.g. Peru [*18*], where female children are considered to have less social and economic potential).
- Children have a low status in society and within the family (e.g. Guatemala [*19*]).
- Physical punishment is an acceptable or normal part of rearing a child (e.g. Turkey [*20*], Ethiopia [*21*]).
- Communities adhere to harmful traditional cultural practices such as genital mutilation (e.g. Nigeria [*22*], Sudan [*23*]) or child marriage (*24*).

Intimate partner violence

- A man has a right to assert power over a woman and is socially superior (e.g. India [*8*], Nigeria [*9*], Ghana [*25*]).
- A man has a right to "correct" or discipline female behaviour (e.g. India [*26*], Nigeria [*27*], China [*28*]).
- A woman's freedom should be restricted (e.g. Pakistan [*29*]).
- Physical violence is an acceptable way to resolve conflicts within a relationship (e.g. South Africa [*30*], China [28]).
- A woman is responsible for making a marriage work (e.g. Israel [*31*]).
- Intimate partner violence is a taboo subject (e.g. South Africa [*32*]) and reporting abuse is disrespectful (Nigeria [*9*]).
- Divorce is shameful (e.g. Pakistan [*11*]).
- When a dowry (financial payment from the bride's family to the husband) or bridewealth (financial payment from the husband to the bride's family) is an expected part of marriage (e.g. Nigeria [*27*], India [*33*]), violence can occur either because financial demands are not met, or because bridewealth becomes synonymous with purchasing and thus owning a wife.
- A man's honour is linked to a woman's sexual behaviour. Here, any deviation from sexual norms disgraces the entire family, which can then lead to honour killings (e.g. Jordan [*34*,*35*]).

Suicide and self-harm

- Mental health problems are embarrassing and shameful, deterring individuals from seeking help (e.g. Australia [*36*], Brazil [*37*]).
- Individuals in different social groups within society are not tolerated – e.g. homosexuals (Japan [*38*]).

Sexual violence

- Sex is a man's right in marriage (e.g. Pakistan [*11*]).
- Girls are responsible for controlling a man's sexual urges (e.g. South Africa [*10*,*39*]).
- Sexual violence is an acceptable way of putting women in their place or punishing them (e.g. South Africa [*10*]).
- Sexual activity (including rape) is a marker of masculinity (e.g. South Africa [*39*]).
- Sex and sexuality are taboo subjects (e.g. Pakistan [*11*]).
- Sexual violence such as rape is shameful for the victim, which prevents disclosure (e.g. the United States [*12*]).

Youth violence

- Reporting youth violence or bullying is unacceptable (e.g. the United Kingdom [*40*]).
- Violence is an acceptable way of resolving conflict (e.g. the United States of America [*41*]).

Community violence

- Cultural intolerance, intense dislike and stereotyping of "different" groups within society (e.g. nationalities, ethnicities, homosexuals) can contribute to violent or aggressive behaviour towards them (e.g. xenophobic or racist violence [*42*] and homophobic violence [*43*]).

Source: WHO (2009)