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Foreword

The Department of Women, Children and People with Disability is tasked with the responsibility of ensuring that the rights of all these three sectors are protected. Women are faced with many challenges that affect most aspects of their lives, from access to health and education to the right to own land and earn a living, to equal pay and access to financial services, to participation in decision-making process at national, provincial and local l evels, to freedom from violence. Over the years, women have fought violence perpetrated against them at all times alone and isolated in their homes, at other times together with other women.

This report focuses on Violence Against Women in South Africa. Despite constitutional protections and a draft of national policy statements gender-based violence remains persistent and wide - spread in South Africa. It transverses a broad spectrum from rape physical violence, psychological abuse, girl child abduction and forced marriage to the "corrective" rape of lesbian women. It takes place in our home, on our streets, in our schools, and universities, in our workplaces, in our farm fields and in our correctional centres and places of safety. This report highlights recently published population-based survey that show especially high levels of intimate partner violence and sexual violence in South Africa, with intimate partner violence being the most common form of violence against women. However, a true picture of the prevalence of violence against women is hampered by under-reporting, as many women are reluctant to report these crimes because of lack of confidence in the security and justice sectors, but also through fear of acts of vengeance and feelings of shame.

Government is deeply concerned by these indicators, and stands firm in its commitment to address violence against women in all its forms. Our message is simple and consistent. Women who are safe, free from the fear of violence, healthy, educated, and fully empowered to realize their potential have the capacity to transform their families, their communities, their economies and the nation as a whole. As Government and as South Africans, we must all work to create the conditions that free women from the scourge of violence and enable women to realize their full potential. As Government we continue to work with a range of state, civil society and private sector actors to ensure the implementation of coordinated policies at all three levels of government and across parallel jurisdictions in an effort to strengthen and sustain an effective national response. Bringing an end to violence against women requires that every South African speak out against relations of power, domination and control that characterize so much of the dynamics of interpersonal relation between women and men in this country. We must embrace our collective role of advocates for respect, justice, equality and women's autonomy. In this, men have special responsibility to carry the message of justice and respect for women's autonomy. Violence against women is not only a woman's issue; it is a men's issue, and tackling this requires redefining masculinity away from the traditional and harmful practices of aggression, force and control. It is our hope and our expectation that this Report-despite its somber message – will serve as rallying point of all South Africans to unite, to hold up their hands and make a commitment to " Stop Violence Against Women".

Ms Lulu Xingwana, MP

Minister for Women, Children and People with Disabilities

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Acronyms

AWR	African Women's Report
CBO	Community Based Organisation
CDC	Centre for Disease Control
CEDAW	Commission for the Elimination of all forms of Discrimination against Women
CEO	Chief Executive Officer
CHW	Community Health Worker
CPD	Continuous Professional Development
CSO	Civil Society Organisation
DG	Director General
DHS	Demographic Health Survey
DoH	Department of Health
DoJ	Department of Justice
DRC	Democratic Republic of Congo
DSD	Department of Social Development
DV	Domestic Violence
DVA	Domestic Violence Act
DWPCD	Department of Women, Children and People with Disabilities
ECD	Early Childhood Development
EXCO	Executive Committee
FCS	Family Violence, Children Protection and Sexual Offences Unit
FGM	Female Genital Mutilation
GBV	Gender Based Violence
GL	Gender Links
HDA	Health and Development Africa
IMC	Inter-Ministerial Committee
ISC	Inter-sectoral Committee
IPV	Intimate Partner Violence
KII	Key Informant Interview

LDAC	Local Drug Addiction Committees
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
LTSM	Learner teacher support materials
MRC	Medical Research Council
NGO	Non-Governmental Organisation
NPA	National Prosecuting Authority
NPF	National Policy Framework on the Management of Sexual Offences
PHC	Primary Health Care
PEIP	Prevention and Early Intervention Programmes
PTSD	Post-traumatic Stress Disorder
PWD	People with Disabilities
SANAC	South Africa National AIDS Council
SAPS	South African Police Services
SBCC	Social Behaviour Change Communication
SOA	Sexual Offences Act
SOCA	Sexual Offences and Community Affairs
SV	Sexual Violence
TTC	Thuthuzela Care Centre
UN	United Nations
UNECA	United Nations Economic Commission for Africa
UNFPA	United Nations Development Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAW	Violence against Women
VOCS	Victims of Crime Survey

Executive Summary

Introduction

Globally, more than one in three women (35.6%) aged 15 and over have experienced physical and/or sexual partner violence, or sexual violence (SV) by a non-partner. The evidence is incontrovertible – violence against women is a profound human rights violation of epidemic proportions. South Africa is no exception. Recently published population-based surveys show especially high levels of intimate partner violence (IPV) and SV, with IPV being the most common form of violence against women (VAW).

South Africa has a strong legislative and policy framework aligned with international conventions that seeks to protect and empower women, as well as a comprehensive set of government programmes and dynamic civil society organisations (CSOs). However, despite these conducive factors, to date interventions to prevent and respond to VAW have had limited impact and gaps exist.

For the purpose of this study, the term VAW is used to encompass IPV and non-partner SV as these are by far the most common forms of VAW in South Africa. The study uses the World Report on Violence and Health's definitions of IPV and SV as they are commonly used in research.

Objectives of this study

In recognition of the urgent need to respond to high levels of IPV and SV, the Department of Women, Children and People with Disabilities (DWCPD) commissioned this study on VAW. This is the first national effort to compile, synthesise and analyse data on the scale, determinants, consequences and responses to VAW in South Africa.

The purpose of this situational analysis is to broaden understanding of the scale, forms and manifestations of VAW in South Africa, and its underlying drivers, in order to:

- Raise the issue of VAW to a higher level on the national agenda;
- Strengthen the coherence of the national response to VAW, by developing evidence-based interventions; and
- Provide a synthetic baseline against which progress can be measured.

Methodology

The data presented in this paper was sourced using a number of approaches:

- Reviewing and analysing available epidemiological data;
- Literature and document reviews;
- Key informant interviews; and
- Through a survey targeted at CSOs.

A Core Technical Task Team comprising of personnel from both the DWCPD and the United Nations Population Fund (UNFPA) monitored the progress of the study and a research experts' reference group appointed by the DWCPD peer-reviewed the draft of the report. The main limitation of the study was the poor response rate received from CSOs to a questionnaire developed to enquire mainly about their programmes on VAW. In addition it was also not possible to access any formal evaluations of government programmes, nor was an interview with the South African Police Services (SAPS) Department possible.

Know your epidemic

In order to know how best to respond to VAW in South Africa, we must first identify the magnitude of the problem and the risk factors surrounding this form of violence.

Two types of data inform VAW in South Africa.

- **Administrative data** which is collected by the police, the court, health and social departments. However it does not measure prevalence or incidence of VAW and only reflects the cases of women whose abuse is reported. This is a small proportion of overall VAW; and
- **Survey data** which provides indicators on the scope, incidence and prevalence of VAW, and associated factors. This report summarises the findings from key population-based surveys undertaken in South Africa that ask about victimisation and/or perpetration of IPV.

Prevalence data

Current available research shows that VAW is highly prevalent in South Africa and interventions to prevent it are urgently needed. Headline statistics are as follows:

- In South Africa, more than half of the women murdered in 2009 (56%) were killed by an intimate partner.
- Overall between 19%-33% of women have ever experienced physical partner violence, but in some population subgroups it may be as high as one in two women.
- Perpetration by men is more commonly reported and population-based studies have reported this among 40%-50% of men.
- SV against intimate partners is less common than physical violence, but very commonly accompanies it. The better population-based studies show the prevalence of having experienced SV to be nearly 20%.
- Men's perpetration of SV whether against a partner or non-partner has been reported by between 28-37% of adult men in the two high quality population-based studies referred to in this report.
- Non-partner SV is particularly common, and the high prevalence of reporting of gang rape is also notable.
- Levels of child abuse reported ranged from 7.3% to 39.1% for girls and is lower for boys (however, the definitions used in the different studies are not the same).

Data from high quality population-based research on VAW is limited and there is no national research mechanism through which VAW surveillance may be undertaken. This is critical for monitoring and evaluating efforts to reduce VAW. There have been many attempts to develop national indicators for VAW, but insufficient attention has been paid to ensuring the quality of the methodology. It is essential that future investment in VAW surveillance prioritises both research quality and adherence to international best practice.

Analysis of the risk factors for IPV and SV in South Africa

To prevent violence, it is important to understand the risk and protective factors that influence its occurrence. Research shows that while IPV and SV occur between individuals, they are influenced by factors that exist at many different levels within society. The study used an ecological model adopted by the World Health Organisation (WHO) to illustrate the different levels at which different factors drive VAW: individual, peer, family or relationship, community and societal levels.

The ecological model shows that a comprehensive response to VAW requires intervention at multiple levels as the risk factors operate at multiple levels and are interrelated. The model further shows that there is no single causal pathway to being a perpetrator or victim. Factors operating at various levels combine to establish the likelihood of occurrence and no single factor is sufficient or necessary. Data presented below has been extracted from research conducted in South Africa.

1 Societal level factors

Two norms within South African society critically influence VAW:

- The readily easy use of violence across social groups and institutions to assert power, achieve power, or punish; and
- Patriarchal gender norms which, notwithstanding the Constitutional rights, position women and girls as having lower social value, power and status to men and boys.

2 Community level factors

- The use of IPV and rape of non-partners has been found to be associated with other delinquent behaviours, including having been or being currently or previously in a gang.
- The link between poverty and VAW is more complex.
    - Rape perpetration is more common among men who are relatively advantaged, or have more power, but living in poor communities.
    - South African research shows that it is not the absolute level of income that predicts the use of violence, but conflicts over household finances, underpinned by issues related to women's power and male identity.

3 Relationship level factors

- Conflict/lack of communication within relationships.
- Having multiple partners both creates risk for women of experiencing IPV and rape, and can be a response to IPV.

4 Main individual level factors

- The individual propensity to use violence also plays a role in VAW. Perpetrators of VAW are individually more likely to use violence of different types. For example men who rape have been shown to be more likely to have been bullies at school.

- The relationship between social power and VAW has also been researched.
    - Although some men, from all educational and economic power levels are violent against women, the greatest risk lies with those who have intermediate levels of power e.g. men who have some tertiary education are more likely to be sexually violent than men who have very low levels of education, or men who have completed qualifications.
    - For women, low social power is linked to violence vulnerability. Women who lack social networks of support, who have no one to talk to about violence in their lives and limited options for leaving abusive relationships are much more likely to experience abuse and less able to avoid repeated abuse experience.
- Exposure to child maltreatment is a well-researched factor for VAW: Having witnessed abuse of one's motheris associated with IPV victimisation and perpetration.
    - More than half of adult women who had ever faced domestic violence had experienced violence in childhood and more than one third had witnessed their mother's abuse.
    - Almost a quarter (23.5%) of men reported witnessing abuse of their mother, and having witnessed such events was associated with their use of physical violence against their partner, among other violent behaviours.
    - Other research studies showed that child sexual assault and forced first intercourse resulted in a greater subsequent risk of physical and/or sexual partner violence and sexual assault by a non-partner. 67.5% of the men who raped were teased and harassed as a child as opposed to 49.5% of the men who had not raped.
- Gender inequitable attitudes
    - The most commonly reported motivation among men who had raped was due to ideas stemming from sexual entitlement. The social acceptability of male sexual entitlement is also reflected in the commonly expressed ideas that women or girls are responsible for their own rape.
    - The connections between having more partners and violence as well as between men's violence and transactional sex have also been established.
    - South African research has particularly highlighted the connection between antisocial personality traits and killing of intimate partners. South African research on men who rape in the general population shows strong associations with dimensions of psychopathy and lower empathy.
    - A bi-directional association was evidenced between IPV victimisation and perpetration with depression.
- Alcohol
    - There is evidence of the association between drinking and greater odds of men perpetrating physical IPV and sexual assault.
    - Women who drink are more likely to become victims, as well as less likely to report the violence to the police.
    - Alcohol is often a source of conflict, especially when scarce resources are spent on it instead of being used for the family.

Some vulnerability factors are not well researched in South Africa and four types of groups of women in South Africa are of particular concern. These are the disabled, the migrant, lesbian women and sex workers. Their

vulnerability is partly because men who are sexually violent very often target women or girls who are seen as having lower social status or power, and because men feel they are less likely to be held accountable for their behaviour. In addition, there is some evidence of harmful cultural practices in some communities, such as forced marriages or murders associated with witchcraft accusations.

The study found a substantial volume of research on VAW prevalence as well as risk factors in South Africa, which is supported by research in other countries. This constitutes a solid base for the development of priorities and prevention interventions.

Analysis of the impacts of IPV and SV in South Africa

VAW has major social and developmental impacts for women, their children and society in general. It is a violation of human rights. The impacts include:

- **Injury:** Two-thirds of women who had ever been abused have been injured and usually on more than one occasion.
- **HIV and STIs:** Young women who are HIV uninfected but have been exposed to IPV are 50% more likely than other women to develop HIV over a period of two years. In addition, 11.9% of new HIV infections could be prevented if women did not experience more than one episode of physical or sexual partner violence.
- **Mental Health:** Domestic violence is associated with the greatest number of lifetime post-traumatic stress disorder (PTSD) cases among women. Rape was found to be the most pathogenic form of violence with regard to PTSD.
- **Complication during pregnancy:** Prevalence of violence during pregnancy is very high in Africa and is a recognised cause of miscarriage, still birth and maternal mortality.
- **Economic impact:** the economic burden of VAW is shared by government, public sector, private sector and society as a whole. This ranges from short-term costs, such as loss of earnings for time-off from work to long-term costs, like medical and psychological treatment. The State incurs expenses in its justice and legal systems, medical and social systems. Private businesses, social welfare organisations, shelters, school systems, medical facilities and communities, also incur extensive expenses and pecuniary losses as a result of dealing with the consequences of the violence.

Not enough is known about the economic and social development impacts of VAW in South Africa and more detailed costing exercises must be conducted. In 2013 WHO published guidelines for an appropriate health sector response to VAW – including post-rape care and training health professionals to provide these services. WHO does not recommend routine case identification (or screening) in health services for VAW exposure, but stresses the importance of mental health services for victims of trauma.

Know your response

South Africa is a signatory to the United Nations *Convention on the Elimination of all forms of Violence against Women.* It is required to report on measures to implement the convention every four years –South Africa submitted reports in 1998 and 2011.

South Africa does not have a national VAW public surveillance system to centrally analyse and disseminate service delivery data collected by the various government departments, or to respond to the indicators mentioned above. However, different government departments collect service-level administrative data and develop indicators and statistics.

South Africa has a comprehensive legal and policy framework related to VAW, in particular the Domestic Violence, 116 of 1998 and Amendment No. 32 of 2007 (DVA) and the Criminal Law (Sexual Offences and Related Matters Amendment Act 2007 (Act No. 32 of 207) (SOA).However,not all officials are familiar with the content of these laws. Furthermore, the DVA was not costed and is under-budgeted; and it does not place any legal obligation on DSD or the Department of Health (DoH).

Crime statistics

SAPS crime statistics reveal high numbers of reported adult female victims of all sexual offences – over 60,000 in the period 2007/2008 to 2011/2012, and 48,325 rapes were reported nationally in 2013. However, this data cannot inform prevalence as SAPS statistics only capture reported crimes. In addition, SAPS does not have a specific crime category for domestic violence and does not publish the data recorded in the Domestic Violence Register. However, SAPS statistics are a useful indication of women's access to the criminal justice system.

The Victims of Crime Survey (VOCS) is a South African countrywide household-based survey which includes data on VAW. However, the number of sexual offences reported in the VOCS 2012 (32,000) is half the number of cases reported to the police the same year, which indicates that sexual offences were largely under reported in this survey and should not be used as an accurate source of sexual assault prevalence, and this limitation is mentioned in the latest VOCS report.

Departmental Government Response to VAW

Department of Social Development (DSD)

DSD is mandated to:

- prevent and respond to VAW;
- monitor prevalence and incidence of gender based violence against women and children; and
- ensure follow-up and support the reintegration of victims of VAW.

However, the DVA does not place a legal mandate on DSD to provide shelter and counselling – consequently these services are guided by policies that cannot compel officials to act. This also weakens referrals between the police station and the shelter.

DSD's flagship initiative,The Victim Empowerment Programme (1999),manages shelters and promotes awareness and education. Other initiatives include coordinating an Inter-Ministerial Committee on the root causes of violence against women and children and tackling the risk factors contributing to VAW, such as adverse childhood experiences and alcohol abuse or delinquency.

Challenges to DSD's response include:

- a severe shortage of shelters compounded by insufficient funding and weak referral systems;
- coordination issues, including at interdepartmental level and within provincial forums;
- duplication of services;
- a lack of evidence-base for certain programmes; and
- issues with the Inter-Ministerial Committee (IMC) processes and outputs which has expanded its remit to develop an overarching programme of action without consulting CSOs.

Department of Justice (DoJ) and constitutional development

The DoJ is mandated with:

- protecting the rights of the vulnerable groups; and
- developing initiatives to implement and monitor the DVA and SOA, at departmental and inter-departmental level.

Several governance structures and programmes are in place to achieve this mandate, such as the DG Inter-Sectoral Committee monitoring the implementation of the SOA.

Recent DoJ achievements include: the National Policy Framework on the Management of Sexual Offences (NPF), which was gazetted in September 2013 and the re-establishment of Sexual Offences Courts – 22 courts are planned, and nine have been put in place so far. The DoJ is also responsible for developing training courses and material, including an interdepartmental Training Manual on Sexual Offences or the Victim Empowerment Programme for frontline staff.

Challenges to DoJ's response include:

- Protection orders – there was a 4% increase in finalised protection orders in 2010-2011, however just over a third of all interim protection orders become final;
- Secondary victimisation in the criminal justice system was reported; and
- Domestic violence criminal prosecutions more than tripled between 2009 and 2010 (3,954 to 14,761). Yet over half of the cases are withdrawn on average.

National Prosecution Authority (NPA)

The NPA's Sexual Offences and Community Affairs Unit (SOCA) is specifically designated to deal with sexual offences. SOCA has developed Thuthuzela Care Centres (TTC) – growing from three in 2001 to 51 in 2013. 50% of the Sexual Offences survivors seeking the services of TTCs report the crime to police. In 2012, cases related to children constituted 57.6% of the cases reported in TTCs as well as 2,003 cases of domestic violence.

The average conviction rate for the second quarter of 2013 increased to 65.8%. However, this conviction rate is based on the number of cases that go to court, not on the total number of cases reported. Based on this, the conviction rate would be only 6.97%, mainly due to deficiencies within SAPS.

Challenges related to the NPA response include:

- lack of coordination between various stakeholders at TTC level;
- insufficient funding for SOCA unit roll out more TTCs; and
- lack of quality standards for TTCs as some are inadequately resourced in terms of staff and material, including rape kits.

Department of Basic Education (DBE)

Schools are an opportunity to put in place preventative and protective interventions for children and promote gender equality values. There is no specific legal mandate placed on DBE to tackle violence against women and children directly. However, the DBE has developed tools to address VAW in schools and conducts training. Since 2011, gender has been included in the Life Orientation curriculumfor Grade R to Grade 12. Further, sexual and reproductive health issues are included in the integrated school health programme.

Challenges to the DBE response include:

- The issue of violence against girls at school does not appear prominently in DBE Action Plan to 2014. CSOs have recently drawn attention to the pandemic of sexual violence in schools and the inadequate implementation of school policies and guidelines on how to deal with sexual offences;
- Research has shown that girls who become pregnant (after rape or in other ways) are often discouraged from continuing their education, despite policy stances to the contrary; and
- The Life Orientation Curriculum is reportedly not always taken seriously by the teachers.

Department of Women Children and People with Disabilities (DWCPD)

The DWCPD mandate has been defined as “promoting, facilitating, coordinating and monitoring the realisation of the rights and empowerment of women, children and people with disabilities.”

DWCPD’s current and main VAW initiative has been to set-up a National Council against Gender Based Violence (NCGBV). The Council envisages developing a costed national strategic plan and hopes to work with other government departments and civil society in its development and subsequent monitoring. Furthermore, DWCPD also manages the 16 days of Activism on Violence against Women, the Orange Day Campaign, and reports against international conventions.

Challenges to the DWCPD response include:

- In 2011, the Committee on the Elimination of Discrimination against Women (CEDAW) noted concerns on DWCPD’s weak institutional capacity;
- Interview respondents had different understandings and interpretations of DWCPD’s roles and responsibilities, accountability mechanisms within the Council as well as the mandated role of civil society; and
- No long-term funding has been secured for Council.

Department of Health (DoH)

The DoH mandate is driven by the Primary Health Care Package, which outlines norms and standards for providing services to SV and IPV survivors. The DVA does not set DoH any legal obligations, however over the last two years DoH has developed several guidelines and policy frameworks that frame its response. DoH's role in the implementation of the SOA is to provide medico-legal services, including providing Post Exposure Prophylaxis (PEP) to victims and HIV testing to people accused of rape, as well as development of training courses on the SOA.

The DoH has developed several frameworks on rape and VAW that are not yet operationalised, and is seeking to establish an institutional framework which would guide other departments to ensure multi-sectorality and to establish designated care services. Other initiatives and achievements include setting up of designated centres for victims of rape, following the TTC model, and developing a national curriculum on post-rape care.

Challenges reported include:

- Secondary victimisation in both TTC and DoH facilities;
- Quality standards are not uniformly implemented; and
- Not enough psychologists are available to provide adequate mental health-care services to survivors.

Coordination issues

- **Duplication ofgovernment coordination structures** was reported during key informant interviews, with various departments developing inter-sectoral strategies, policies or action plans and putting in place different coordination forums that largely overlap. This duplication is partially rooted in the legislative and policy mandates of the departments.
- **Mistrust between government and CSOs** was also reported as an issue by the majority of the interview respondents.
- **A lack of coordination within the NGO sector,** compelled by competition for funding was also noted.
- **Lack of coordination between donor and UN agencies,** despite the DWCPD coordinated Donor Coordination Forum. This has led to some duplication of initiatives.

The way forward envisaged by DSD and DWCPD is that the IMC on the root causes of violence against women and children would be integrated into the GBV Council. Respondents had different views on the Council governance structures in general and the role of the IMC in particular, as well as which entity would have overall accountability.

Mapping the NGO response

CSOs are the biggest provider of VAW primary prevention and secondary intervention services. This study selected key organisations in the field and conducted a mapping exercise aimed at determining the types of programmes the CSOs implement (in particular the balance between primary prevention and secondary interventions); their reach and geographic coverage of their programmes; the number of programmatic evaluations conducted and the results thereof; as well as programme implementation budgets.

The mapping exercise revealed:

- A clear imbalance between primary prevention and secondary prevention activities, with a stronger focus on the latter;
- Most efforts focus on strengthening the criminal justice system through supporting survivors' access to services and providing counselling services, as well advocacy; and
- The most common activity is around the training beneficiaries, organisational staff and volunteers, as well as advocacy and lobbying to government departments.

CSOs are central to implementing the SOA and DVA and filling in gaps related to the implementation of these Acts – in particular providing psychological services, ensuring referrals/making services available, and lobbying government departments. In terms of primary prevention, it is encouraging to note that nearly half of the organisations work on changing social norms on VAW, and just over a quarter are working towards promoting economic empowerment of girls and enhancing educational attainment – proven protective factors against IPV. This is important because, interventions that do not address social norms and challenge patriarchal attitudes are unlikely to lead to social change.

Mapping social and behaviour change communication (SBCC) interventions

SBCC encompasses a number of different approaches which operate at different levels within the socio-ecological model, and includes: mass media, small media, interpersonal communication (IPC), advocacy and social mobilisation. Relatively few South African SBCC initiatives address VAW.

Of the 12 SBCC campaign interventions analysed by this study, only seven have been evaluated (or have made their evaluations available to the public). The methods and rigour used to evaluate these interventions vary widely and few have been rigorously evaluated. A clearly articulated theory of change is crucial to measuring SBCC impact.

Despite limited evaluation data, there is evidence to suggest that SBCC interventions can influence intermediary factors such as knowledge, attitudes and self-efficacy as well as actual behaviour.

Identified prevention good practices

The literature review and interviews showed that few approaches to preventing or responding to VAW have been rigorously evaluated, whether by government departments or CSOs. Where they have been conducted, the evaluations generally have not measured outcomes at behavioural and attitude levels, and in particular have not demonstrated actual reductions in levels of violence.

However, a few intervention evaluations have measured the association between exposure to intervention components and behaviours, and two internationally acknowledged randomised control trials implemented in South Africa proved the links between economic and/or social empowerment of women and decreased IPV: the *Intervention with Microfinance for AIDS and Gender Equity (IMAGE),* and the *Stepping Stones intervention.* Despite strong evidence related to these two interventions, only *IMAGE* has been scaled-up.

Does South Africa's response address VAW effectively and comprehensively?

Outlined in the bullets below is an assessment of South Africa's response against some of the UN's recommended indicators for measuring the effectiveness of the State response:

- **Indicator - An effective legal framework, statute and procedural law that provides access to justice, redress, protection and compensation.**

  Assessment - The DVA and SOA provide access to justice, protection and compensation but are under-funded and the governance mechanisms guiding implementation of the legal framework are not entirely effective. The DVA does not place any obligations on DSD, DoH or DBE.

- **Indicator - Criminalization of all forms of violence against women and the prosecution of its perpetrators.**

  Assessment - Forms of violence are criminalised but under-reporting is high and conviction rates are low.

- **Indicator - A plan of action/executive policy on VAW with a strong evidence base and political will for its implementation, demonstrated by budgetary allocation, timelines and clear paths of responsibility.**

  Assessment - There are several multi-sectoral plans of action guiding the VAW response but no overarching plan endorsed by all stakeholders or clear lines of accountability. There is a duplication of coordination forums. Plans and programmes are not systematically based on evidence and there are not enough evaluations. Budget allocation to VAW is insufficient. Good coordination initiatives exist though, through the Joint Gender Fund.

- **Indicator - Increased awareness and sensitivity of professionals and officials.**

  Assessment - Government officials are trained, but there is no evidence of the quality and effectiveness of the training. Very few departments could provide data on number of people trained and none provided evidence on the impact of the training.

- **Indicator - Resource allocation to ensure provision of support and advocacy services by NGOs, including shelters, helplines, advocacy, counselling and other services.**

  Assessment - The resource allocation to NGOs is insufficient and inconsistent and they rely heavily on donor funding – this leads to under-funding of shelters, as well as of support and advocacy related activities. The role of NGOs in the development and monitoring of VAW plans remains unclear.

- Indicator - Awareness raising and prevention programmes.

  Assessment - Awareness raising campaigns exist but are not rigorously evaluated. Evidence of effective prevention interventions exists, but they are not sufficiently scaled up. Prevention interventions are not systematically linked to VAW risk factors and consequences.

- **Indicator - Addressing structural inequalities in the promotion of women's advancement**

  Assessment - Patriarchal values are still influential in society but coexist with innovative organisations working to redefine gender norms. Recent legal frameworks focus on women's vulnerability, thereby positioning women as passive recipients in need of support instead of active rights holders. Addressing societal-level factors such as patriarchy is crucial to preventing VAW and more efforts on this are needed in South Africa.

- **Indicator - Collection, collation and publication of data, including evaluation of policies and basic research programmes.**

Assessment - Data collection and publication sites are scattered among NGOs and research institutes, and need to be centralised in one accessible point.

Recommendations

The section below presents recommendations for policy makers, donors, programme implementers as well as researchers. The recommendations respond to the research questions proposed by the DWCPD and UNFPA in the Study ToR. These recommendations are not prioritised and do not specify roles and responsibilities for implementation, as this was beyond the scope of this report. Rather, it is expected that these recommendations will be discussed and prioritised during a consultative workshop gathering key VAW stakeholders in South Africa. It is expected they will further be translated into a national VAW Action Plan.

Priority interventions

VAW interventions have been shown to be much more effective when they target multiple risk factors and operate at multiple levels. Based on this, this study recommends the following (related examples of effective programmes are outlined in the main body of the report).

- **Interventions to change social norms around masculinity and gender relations:** Social norms around gender relations and ideals of masculinity play an important role in the risk of men and boys perpetrating VAW. Interventions need to address these norms at societal or community level, as well as at individual level.
- **Interventions to change social norms around the use of violence:** An important part of VAW prevention involves reducing the social acceptability of VAW and the use of violence in social relations more generally. A critical part of social learning occurs in childhood and so reducing the use of corporal punishment at home and in school is essential to this agenda. Research has also shown that prevention of domestic violence is essential both in its own right and as part of efforts to reduce broader violence and crime in society – interventions that effectively reduce societal levels of IPV may also impact on other forms of violence.
- **Reducing the propensity for men to be aggressive, impulsive and remorseless through interventions in childhood:** Reducing exposure to all forms of adversity in childhood is essential for reducing perpetration of violence. To achieve this, there is a need to change social norms around parenting to enhance perceptions of the responsibility of both parents for child protection, to reduce the use of violence in parenting, to enhance understanding and the use of appropriate non-violent discipline, and to enhance communication and engagement with children. Child protection systems must be better resourced and able to identify vulnerable children and families and act to protect them.
- **Reducing teenage male school dropout, unemployment and underemployment:** Interventions to get teenage boys and men into gainful employment, study and recreation are critical for reducing their propensity to hang out in contexts where they may engage in violent and antisocial behaviour.
- **Reducing binge drinking:** Interventions to reduce binge drinking are an important part of the overall agenda for VAW prevention.
- **Enhancing relationship skills: I**nterventions that build relationship skills and respect between men and women help reduce conflict in relationships and thus VAW.
- **Enhancing the social and economic empowerment of women and girls:** These interventions enable women and girls to protect themselves from victimisation and to support themselves should they want to leave a violent relationship.

- **Strengthen formal and informal legal, health and social support structures:** This increases the social and legal accountability for violence and reduce the impacts of VAW. Even though only a small proportion of men who rape are reported to the police, vigorously pursuing these cases can send an important message that rape cannot be perpetrated with impunity. This can also prevent patterns of repeat offences, which is common in both rape and IPV.
- **Strengthening healthservices, especially mental health services:** Mental health services are vital for treating depression as a risk factor for VAW and reducing the trauma-induced risks that result in women who have experienced VAW, especially rape, remaining at heightened risk of repeated victimisation.
- **Conduct HIV prevention activities addressing the link between IPV and risk behaviours as well as gender inequitable norms.**

Given the scale of VAW in South Africa, there is clear need for well-designed robust SBCC programmes on VAW, aimed at changing the social norms on gender.

What could be done to ensure more effective implementation of VAW programmes in South Africa?

- **Scale-up proven good practices that have been tested in South Africa**: e.g. microfinance for women and empowerment training.
- **Improve monitoring and evaluation:**
    - ***Conduct external rigorous evaluation of governments' and CSOs programmes,*** which would enable these to be strengthened and clarify their effectiveness. These evaluations could also describe the comparative advantages of each government department and CSOs in conducting various types of interventions, in order to avoid duplication;
    - Develop time-bound **action plans** with clear roles and responsibilities and accountability mechanisms on each programme;
    - Link the various programmes' M&E frameworks and coordination forums.
- **Increase funding for VAW prevention and response:**
    - Analyse the cost of VAW in South Africa;
    - Analyse resource allocation on both response and prevention;
    - Develop a VAW prevention budget and realistically fund prevention and response to VAW.
- **Improve existing government programmes**
    - **Develop norms and standards**
        - For the training for all government officials as well as evaluation guidelines that would test the quality and effectiveness of the training;
        - For the one stop centres (and rationalize them based on the comparative advantage of the departments);
        - For the shelters
    - **Shelters**: increase funding and develop funding guidelines, strengthen and widen the scope of the economic empowerment opportunities offered to women and make provisions for children.

- **Improve the legal framework**
  - **White Paper on Families:** Revise the paper to better consider the need to strengthen proven initiatives aimed at women's empowerment and at changing norms;
  - Finalise the amendment of the DVA
    - Revise governance mechanisms
    - Legislate on the role of DoH and DSD, as well as DBE
    - Cost the DVA
  - Define domestic violence as a criminal offence in its own right and mandate annual reporting of the number of police cases of domestic violence against women by male intimate partners and number of protection orders applied for and finalised for this category of domestic violence.

How can we promote social and behaviour change in relation to positive norms around VAW?

Given the scale of VAW in South Africa, there is clearly a need for well-designed robust communication programmes on VAW aimed at changing the social norms on gender. Some considerations for designing and implementing an SBCC programme include:

- Development of a clearly articulated theory of change as to how exposure to the campaign aims to impact on intermediary factors and behaviour;
- Formation of a multi-disciplinary and cross-sectoral steering committee to guide the strategic direction and effective implementation of the campaign;
- Conducting formative research to clearly identify the target audience(s), key messages and approach to be used;
- Ensuring a national campaign that goes beyond addressing the individual, but also aims to impact at multiple mutually reinforcing levels including individual, community and socio-political environments;
- Ongoing monitoring and rigorous evaluation, which addresses attribution and is based on the theory of change.

Coordination: How to increase unity of purpose, synergy, effectiveness and impact? What needs to be in place to ensure a unified, coordinated and sustainable multi-sectoral approach to VAW?

The GBV Council is still in its infancy and has yet to put in place the various governance mechanisms required to start functioning fully. The announcement that the IMC would merge with the GBV Council and the as yet unclear role of civil society in the Council indicates the need to reconceptualise governance structures and accountability mechanisms. In the light of duplication, service delivery and budget challenges, it seems that the main function of the GBV Council should be to ensure accountability, avoid duplication and allow for a scaling up of good practices. It should also improve collaboration between CSOs and government departments, and in particular use the technical expertise of civil society, including the research sector, in the development of programmes and policies that govern the services they implement.

Based on the above, the following recommendations can be made:

- Restore confidence and interest of all stakeholders (CSO, research sector and government departments)

in a multi-sectoral approach;

- Clarify the mechanisms of governance of the GBV Council and communicate them to all stakeholders, taking into consideration the merger with the IMC;
- Clarify and communicate who will ensure the overall accountability of the implementation of the over-arching plan and how;
- Clarify the functions of the GBV Council, taking into consideration the comparative advantages of each government department and CSOs; and
- If the SANAC (South African National AIDS Council) model is to be followed:
    - It is important to learn from SANAC and avoid repeating mistakes in the design of the governance mechanisms;
    - The GBV Council could be chaired by a senior political representative who has a very high level of political and institutional authority, such as the Deputy President; and
    - CSOs could have a role in developing and monitoring the plan.

Further recommendations on coordination

- Rationalise coordination at all levels;
- Strengthen donor coordination to avoid duplication;
- Develop a national integrated M&E system on VAW, based on existing indicators collected and develop a monitoring tool;
- Centralise administrative data and research on VAW.

Which areas need further research?

This report showed that reliable data informing on the scale of the IPV and SV epidemic in the general population exist in South Africa, even though there is no rigorous mechanism for population-based surveillance of VAW. It also showed that the response does not match the scale of the epidemic and is not sufficiently informed by research. More emphasis should also be placed on primary prevention of VAW. Based on these gaps, further research is needed on the following areas:

Include questions on violence against women in the next Demographic and Health Survey

- The next South African Demographic and Health Survey can provide a good platform for gathering data on violence against women, providing that data collection methods are guided by international ethical and safety guidelines. It is hoped that this survey will be implemented in 2015.

Research to monitor the response

- National coverage of interventions (looking at their scope, population reach and geographical coverage); and
- Trends in key indicators of the VAW response, such as number of health professionals trained in post-rape care or on VAW.

Research on primary prevention intervention, response evaluation and scale up

- Develop and test the effectiveness of IPV/SV primary prevention interventions – particularly school based and parenting interventions;
- Evaluate existing interventions that seek to prevent sexual violence;
- Conduct systematic rigorous localised baseline/situational analysis to tailor interventions to local needs and realities;
- Conduct research on how to scale up the interventions that work;
- Conduct research on the costs of preventing VAW and the impact of scale up on costs and effectiveness; and
- Conduct research to develop and test interventions for vulnerable groups

What should be done to improve VAW data collection and analysis?

Surveillance and monitoring of trends

- A national surveillance system for VAW needs to be established and resourced so that the impact of interventions on the general population can be measured and monitored over time. The system must prioritise quality assurance and draw on locally and international good practice, recognising the methodological and ethical difficulties of research in this field; and
- A key indicator list that should be measured and monitored should be developed and must include:
    - Past year prevalence of physical, sexual and emotional IPV, non-partner sexual violence, including injury, reporting to police and accessing counselling;
    - Intimate femicide and rape homicide;
    - Reports to SAPS of rape matters;
    - Case attrition in the criminal justice system;
    - Trends in IPV and rape perpetration risk factors; and
    - Trends in prevalence of vulnerable groups including lesbians and women with disabilities.

Introduction and Background

1 Background

Globally, more than one in three women (35.6%) aged 15 and over have experienced physical and/or sexual partner violence, or sexual violence by a non-partner. The evidence is incontrovertible – violence against women is a profound human rights violation of epidemic proportions.

> *"Violence against women and girls continues unabated in every continent, country and culture. It takes a devastating toll on women's lives, on their families, and on society as a whole. Most societies prohibit such violence — yet the reality is that too often, it is covered up or tacitly condoned."*
>
> Ban Ki Moon, UN Secretary General.

South Africa is no exception. Recently published population-based surveys show especially high levels of intimate partner violence (IPV) and non-partner sexual violence (SV), with IPV being the most common form of violence against women. Over half of women homicide victims are killed by their intimate male partners.[1] Overall, 37.7% of women living in Gauteng have ever experienced physical and/or sexual IPV, with 18.8% having ever experienced sexual IPV. Forty six per cent (46.2%) of women have ever experienced emotional or economic abuse.[2] The rape of a woman or girl has been perpetrated by 27.6% of men in the Eastern Cape and KwaZulu-Natal (KZN)[3], and 37% of men from Gauteng.[4]

There is growing recognition of the magnitude of violence against women (VAW) and of the need to strengthen the response across sectors. In March 2013, 103 member states at the fifty-seventh session of the Commission on the Status of Women at the United Nations (UN) headquarters in New York took a stand to end violence against women and girls and to promote and protect their human rights and fundamental freedoms. The session also highlighted the importance of collecting relevant VAW data.

South Africa has a strong legislative and policy framework that is aligned with international conventions and seeks to protect and empower women. This is complemented by a comprehensive set of government programmes and dynamic civil society organisations. However, despite this enabling environment, to date interventions have had limited impact.

There is a strong body of research on VAW in South Africa, but this data has yet to be pulled together to enable policymakers to develop evidence-based programmes. Data is available, but it is not always accessible and the quality is not always clear. Hence the need to know what data exists, how it can be used to inform programmes and policy and what additional data we need to respond effectively to the epidemic and hopefully prevent it. In order to develop appropriate and effective programmes for women, we need to better understand both the epidemic and the response.

In recognition of these data gaps and the urgent need to respond to high levels of IPV and SV, the South African Government established the National Council against Gender-Based Violence and the Inter-Ministerial Committee (IMC) on the Root Causes of Violence against Women and Children.

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1 Abrahams et al, 2013
2 Gender Links and Medical Research Council (MRC), 2010
3 Jewkes et al, 2009
4 Gender Links and Medical Research Council, 2010

This study has been commissioned by the Department of Women, Children & People with Disabilities (DWCPD) to assist these entities in their efforts to respond to and prevent VAW in South Africa. This is the first national effort to compile, synthesise and analyse data on the scale, determinants, consequences and responses to VAW in South Africa.

2 Objectives of the study

The purpose of this situation analysis is "to conduct a study so as to broaden our understanding of the scale, forms and manifestations of violence against women in South Africa, and its underlying drivers", in order to:[5]

(a) Raise the issue of VAW to a higher level on the national agenda;

(b) Strengthen the coherence of the national response to VAW, by developing evidence-based interventions;

(c) Provide a synthetic baseline against which progress can be measured;

(d) Serve as a tool for decision making.

The research questions are:

Know your epidemic

- What is known about the scale (prevalence and incidence) and manifestations (different types) of VAW in various settings in South Africa?
- What is known about the trends of different types of VAW in South Africa?
- What is known about the impact of VAW?
- What are the protective factors?
- What is known about the risk factors for VAW?
- How is data being collected and analysed on VAW? What indicators are being used to collect data and what is the national VAW measurement system and how is it currently structured?

Know your response

- What is the nationwide institutional response to VAW (including government and civil society)?
- What evidence is documented as good practice on VAW prevention, and what are the most important gaps?
- What failed in past communication strategies, and what has worked?

Recommendations

- Which areas would need further research?
- Which types of intervention should be prioritised?
- What could be done to ensure more effective and sustainable implementation of VAW programmes in South Africa?
- What should be done to improve VAW data collection and analysis?

[5] The objectives and research questions presented were defined in the VAW Study Terms of Reference.

3 Definition of VAW

For this report, the following definitions are used:

Violence against women (VAW) as defined by the UN Commission on the Status of Women is *"any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women and girls, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life".*[6]

For the purpose of this study, the term VAW will be used to encompass intimate partner violence (IPV) and non-partner sexual violence (SV) as these are by far the most common forms of VAW in South Africa. This study has adopted the definitions of IPV and SV proposed by the World Report on Violence and Health[7] and most commonly used in research. The definitions of emotional and economic violence adopted in this study are the ones used in the available population-based surveys conducted in SA. The focus of this paper is on adult women – over 15-years-old.

Intimate partner violence: *"Behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours. It covers violence by current and former partner or spouse".* This definition includes violent acts and threats of violence as well as emotional violence and economic violence.

Sexual violence: *"Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting including but not limited to home and work".* This study does not include data on trafficked women as the issues pertaining to this group are of a different nature to the issues relating to SV and IPV.

For research purposes, emotional and economic violence have been defined as follows in the research papers quoted in this document. However, individual women may experience a broader range of acts that cause them psychological or economic harm, for example the most widespread economic violence perpetrated by ex-partners is non-payment of child maintenance.

Emotional violence: *"To have ever been boasted about or have girlfriends brought home; ever stopped from seeing friends; threatening to hurt; ever done things to scare or intimidate; ever belittled or humiliated in front of other people; and ever insulted or been made to feel bad".*

Economic violence: *"Not to be given money for home essentials when a partner has it; forcibly evicted woman or children from home; taken her earnings; and [ever been] forbidden to work or earn".*[8]

The terms **victims** and **survivors** are used interchangeably in this report.

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6 UN CSW, 2013, based on A/RES/67/144, OP1
7 Heiseet & Moreno, 2002
8 MRC study, 2010

4 Methodology of the research

The information presented in this paper was sourced in multiple ways, including:

- review of available epidemiological data and, where appropriate, secondary data analysis of existing data sets;
- literature review including government reports;
- key informant interviews;
- survey of civil society organisations.

Epidemiological data

The VAW study identified, analysed and synthesised available published epidemiological data in South Africa, including past year and lifetime prevalence IPV, SV, emotional violence and economic violence data, as well as risk factors. Secondary analysis of original data sets was carried out. Data relating to perpetration and victimisation of IPV in the past year by demographic category was analysed from an existing dataset.

Literature review

VAW epidemic, its causes and consequences

A web-based literature search using the search engine PubMed was conducted to identify relevant journal articles (key words included: VAW South Africa, IPV South Africa, SV South Africa and VAW SBCC). Peer-reviewed publications, such as national and international reports, as well as grey literature were included in the review when needed.

Government response and data collected by government departments

Quantitative data collected by national government departments was gathered and consolidated to enable reflections on routinely collected data on VAW, its strengths and its limitations. This includes data collected by the South African Police Services (SAPS), Department of Justice (DoJ), National Prosecuting Authority (NPA) and Correctional Services.

Annual reports and Annual Performance Plans together with any other document related to VAW, such as programme descriptions or training manuals, were downloaded from government websites – Department of Social Development (DSD), DWCPD, DoJ, Department of Basic Education (DBE), SAPS, Department of Health (DoH). However, most of the documentation on the government response was obtained during key informant interviews and consisted of draft policies and programmes, unpublished draft reports, and training manuals. Meeting reports and parliamentary hearings related to VAW were also sourced through web searches on the Parliamentary Monitoring Group website.

Literature on civil society response to VAW

Literature pertaining to the civil society response to VAW in South Africa since 2003 was reviewed. Documents were sourced through a web search and direct requests to non-governmental organisations (NGOs) via

emails. Literature included descriptions and evaluations of programmes, case studies on identified good and innovative responses, and social behaviour change communication campaigns (SBCC) on VAW.

Questionnaire to map the civil society response

A questionnaire was sent electronically to 26 civil society organisations (CSOs). It used closed questions to identify areas of work, number of programme beneficiaries, programme budgets, and evaluation findings (see questionnaire in **Annexure 2**). Out of 26, seven completed questionnaires and three evaluation reports were received.

Key informant interviews

Eleven semi-structured interviews were conducted with national government representatives (see list in **Annexure 1)** and two with CSO representatives. Purposive sampling was used and informants were selected with the support of the Core Technical Task Team (see below). The interviews gathered information on current programmes and future plans, achievements and challenges, as well as views on coordination issues and recommendations.

Consultative, quality assurance and management processes

Several consultative and quality assurance processes were put in place to assist information gathering and validation, and to strengthen study findings.

The Core Technical Task Team role was to provide quality assurance, guidance and support to the research team in accessing information, specifically government departments' programmatic response to VAW. The team also helped select relevant stakeholders for interviews, and met once a month to monitor progress and review the research draft reports. The team was composed of representatives from the DWCPD, United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF), Centre for Disease Control (CDC) and Health and Development Africa (HDA).

A research experts' reference group was constituted to peer review the report, verify and complement the data and to quality assure the study's methodology and analysis. The group was composed of eightresearchers with proven track records in the field of VAW in South Africa. A senior technical advisor, Professor Rachel Jewkes, was appointed to provide on-going advice and coordinate the section on prevalence **(see Annexure 1).**

HDA was responsible for overall analysis and synthesis of the data gathered for the report. The Medical Research Council (MRC) wrote the section on epidemiology and reviewed the report.

5 Constraints and limitations of the review

Despite several attempts to obtain feedback, the response rate to the NGO questionnaire was poor – only seven of the 27 NGOs approached responded. Furthermore, only two civil society representatives could be interviewed for this report. Recommendations on how to better map the civil society response are made in the final section of this report.

The study could not access any formal evaluations of government programmes and it was beyond the scope of the project to conduct programme assessments. As a result, the government response section is only able to present a partial inventory of national government programmes' achievements and challenges. It was also beyond the scope of this study to analyse the government response at provincial, district and local levels.

It was not possible to obtain an interview with the SAPS, so the activities, programmes and challenges of this department are not reported.

Chapter I: Know your epidemic

Violence against women in South Africa is a profound and pervasive public health and Human Rights problem. In order to know how best to respond to this epidemic, we must first identify the magnitude of the problem and the risk factors of this form of violence. This chapter summarises data on IPV by type to help us better understand how the epidemic manifests itself in South Africa, both nationally, and where data allows, by province and subgroup. It also presents data on rape. Strengths and limitations of these datasets are also discussed.

Knowledge on the VAW epidemic can be drawn from qualitative and quantitative research. There are two ways of quantitatively measuring elements associated with VAW: through the collection and analysis of administrative data by government department and service delivery point, or through surveys. Both types of data inform on different aspects of VAW.

Administrative data is collected by the police, the court, health and social departments or other service providers. This data, and the statistics derived from it, does not measure prevalence or incidence of VAW as it only reflects those cases where abuse has been reported or has otherwise come to the attention of the authorities – this is a small proportion of overall VAW. These indicators help monitor access to services and ultimately monitor the coverage of measures undertaken to respond to VAW – they are presented in chapter 2 of this report.

Survey data provides indicators on the scope, incidence and prevalence of VAW and associated factors. Since most cases of VAW are not reported to the police nor do they result in hospital emergency department visits, surveys are the only way to accurately measure prevalence and incidence of VAW.

Population-based surveys, non-population based studies of VAW and qualitative research have provided a wealth of information on factors associated with experience of VAW (whether victimisation or perpetration). Ethnographic research has hugely deepened our understanding of the contextual dynamics in which violence occurs.

The key South African population-based surveys that ask about victimisation and/or perpetration of IPV are summarised in table 1 below. Subsequent discussion on prevalence will focus on findings from those population-based studies that are more valid or have fewer identified methodological problems (the studies are quoted in footnotes).

The body of research from South Africa, read together with international research literature, enables us to have considerable confidence about the underlying causes of violence from which to develop a programme of action for prevention.

Table 1: Key South African population-based surveys regarding victimisation and perpetration of IPV

Study name/year	Location/size	Design	Measure	Notes on the survey
Three Provinces Study, 1998	Eastern Cape (n=405 women), Mpumalanga (n=428 women), Northern province (n=477 women)	Cross-sectional household survey	Victimisation among women 18-49 yrs	The measure of sexual violence was quite far from what is now considered best practice. Interviewer administered.
1998 South Africa Demographic & Health Survey (SADHS)	National 11,000+ women	Cross-sectional household survey	Victimisation among women 15-49 yrs	This survey was validated through the Three Province Study and the conclusion was that the SADHS estimates were of poor validity. Interviewer administered
2004 Foundation for Human Rights funded survey done by Social Surveys	National	Cross-sectional household survey	Victimisation	This research was never finalised as the survey design and implementation was highly flawed. Interviewer administered
HSRC South African Social Attitudes Survey (SASAS) Dawes et al 2003	National, sub-sample of 1,198 men and women aged 16+ yrs with partners from the SASAS, (83% married, 17% cohabiting or partnered unmarried)	Cross-sectional household survey	Victimisation and perpetration between partners over 16 yrs	The sample is not representative of exposed adult women and men, as more than 50% of women in the adult population are married. The violence measure also did not include beating.
Jewkes et al 2008 Kwazulu Natal and Eastern Cape Men's Study	Kwazulu Natal and Eastern Cape (n=1,737)	Cross-sectional household survey	Perpetration among men 18-49 yrs	This used a modified version of the WHO's gold standard measure of IPV. Self-reported perpetration.
Gender Links/ MRC study, 2010 Gauteng Province	Gauteng (n=511 women, n=487 men)	Cross-sectional household survey	Victimisation, perpetration, aged 18 yrs and over	This used the WHO's gold standard measure of IPV. Interviewer administered
Gender Links, 2012 Western Cape, KwaZulu Natal, Limpopo province	KwaZulu Natal (n=699 women and n=595 men), Limpopo (n=841 women, n=1,000 men) , Western Cape (n=750 women, n=741 men)	Cross-sectional household survey	Victimisation, perpetration, aged 18 yrs and over	Not finalised, provincially representative estimates not available. Interviewer administered

In addition to these large studies, there are also a number of subject-specific, well-conducted studies available on VAW using non-population based samples that can deepen our understanding and better inform our responses and prevention programmes (e.g. intimate femicide). Where appropiate, these studies are also included in this report.

The sections below present what we know about VAW in South Africa. The first subsection presents the prevalence data. The second and third subsections analyse the risk factors and consequences of VAW as documented in South African literature.

1.1 Prevalence data

Methodological issues

The most important indicators of VAW in the general population come from well-conducted population-based studies. In this section the key indicators from these studies are presented. Some caution is required when making comparisons across studies due to differences in: the wording of questions on VAW, the study methodologies, including age of participants, and the time at which they were conducted.

International recommendations on prevalence research on VAW highlight that the estimates found are highly dependent on the methodology used. A number of criteria have a major impact on level of disclosure and prevalence reported. These include: wording of questions, duration of training of interviewers (over one week), referral links for participants when needed, and emotional support for interviewers when conducting the fieldwork, as well as context of the interviews and the empathy perceived by respondents. Many of the South African studies do not follow these basic recommendations, so their estimates need to be treated with caution.[9]

1.1.1 Physical partner violence

Women's experiences

The proportion of ever partnered women who have experienced physical partner violence, or experienced it in the last 12 months are the most commonly used measures to assess prevalence of physical partner violence. Prevalence of physical IPV in South Africa can be sourced from two datasets – the MRC's Three Province Study (1998) and the Gender Links & MRC study of Gauteng (2010).[10] Figure 1 below provides a summary of the IPV prevalences found in these studies. It shows that IPV prevalence rates across studies range between one in five and one in three women reporting ever having experienced physical IPV in their lifetime (19.1%-33.1%), and between one in eight and one in twenty having experienced it in the past year (4.5-13.2%).

Between one in five and one in three women have reported ever having experienced physical intimate partner violence in their lifetime (19.1%-33.1%)

These levels are substantially lower than those found in high quality research conducted among subgroups of the population. For example Dunkle et al's study of women in antenatal care in Soweto (n=1395) found that

[9] WHO, 2013
[10] Gender Links, 2012

50.4% of women had experienced physical partner violence and 25.5% had experienced it in the 12 months before the interview.[11] In the rural Eastern Cape, 36.6% of ever partnered women aged 15-26 years enrolled in the Stepping Stones study (n=1365) had ever experienced physical partner violence and 28.4% had done so in the year prior to the study's first interview.[12]

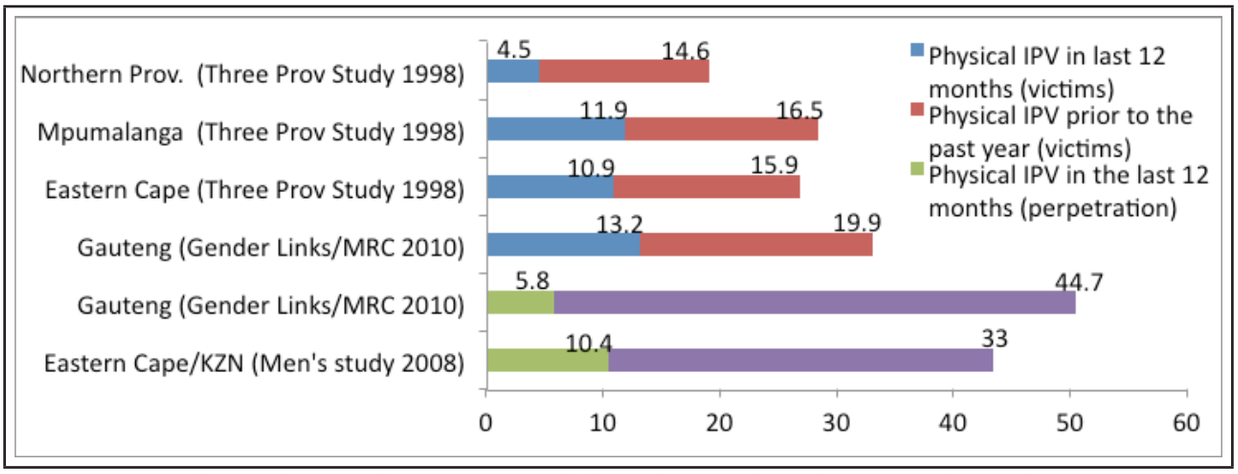

Figure 1: Prevalence of women's experiences of physical IPV and men's perpetration in the past year and prior to the past year, in high quality population-based studies

No population-based studies have been conducted in the Northern Cape, North West and the Free State.

Men's perpetration of physical violence against a partner

Population-based research on physical IPV perpetration is also limited, with estimates available from the MRC survey conducted in three districts of the Eastern Cape, and KwaZulu Natal in 2008 and the Gender Links/MRC survey conducted in Gauteng in 2010.[13] These studies show that between 40-50% of men disclose having ever perpetrated partner violence and between 6-10% having done so in the previous year (Figure 1 above).

Studies show that between 40-50% of men disclose having ever perpetrated partner violence and between 6-10% having done so in the previous year.

There are two high quality non-population based studies with which these figures can be compared. Abrahams et al interviewed a randomly selected sample of men working for the municipality in Cape Town (n=1378) and found that 42.3% had ever been physically violent to a partner in the previous 10 years and 8.8% had been physically violent in the past year.[14] In the rural Eastern Cape, 28% of ever partnered men aged 15-26 years enrolled in the Stepping Stones study (n=1307) had ever been physically violent towards a partner and 21.5% had done so in the year prior to the study's first interview.[15]

[11] Dunkle et al, 2004
[12] Jewkes et al, 2008
[13] Machisa et al, 2011
[14] Abrahams et al, 2006
[15] Jewkes et al, 2008

1.1.2 Sexual intimate partner violence

Women's experience of sexual intimate partner violence

Figure 2 below shows the prevalence of exposure to sexual IPV. The proportion of women reporting ever having experienced sexual IPV was nearly one in five in Gauteng, but much lower in the Three Province Study. The latter may be due to the Three Province Study[16] using a rather weak question to measure sexual IPV. The proportion of women disclosing lifetime victimisation in the Gender Links/MRC study[17] in Gauteng was very similar to that of men reporting perpetration.

Nearly one in five women in Gauteng (33.1%) has reported ever experiencing sexual intimate partner violence.

Non-population based research provides estimates in the same range. Dunkle et al's 2004 study found that 20.1% of women had experienced sexual partner violence and 9.7% had experienced it in the 12 months before the interview.[18] In the rural Eastern Cape, 16.4% of ever partnered women aged 15-26 years enrolled in the Stepping Stones study (n=1365) had ever experienced sexual partner violence and 11.9% had done so in the year prior to the study's first interview.[19]

Men's perpetration of sexual intimate partner violence

The prevalence of perpetration of SV against an intimate partner from household surveys is presented in Figure 2. The population-based studies show that between 15-20% of men have forced a partner into sex and about one in twenty (5%) have done so in the last year.

Between 15-20% of men have forced a partner into sex and about one in twenty have done so in the last year.

If this data is compared to non-population based studies, Abrahams et al found that 15.3% of men had ever been sexually violent to a partner in the previous 10 years.[20] In the rural Eastern Cape, 8.4% of ever partnered men aged 15-26 years enrolled in the Stepping Stones study (n=1307) had ever been sexually violent towards a partner and 6.7% had done so in the year prior to the study's first interview.[21]

[16] Jewkes et al, 2002
[17] Gender Links and MRC, 2010
[18] Dunkle et al, 2004
[19] Jewkes et al, 2008
[20] Abrahams et al, 2006
[21] Jewkes et al, 2008

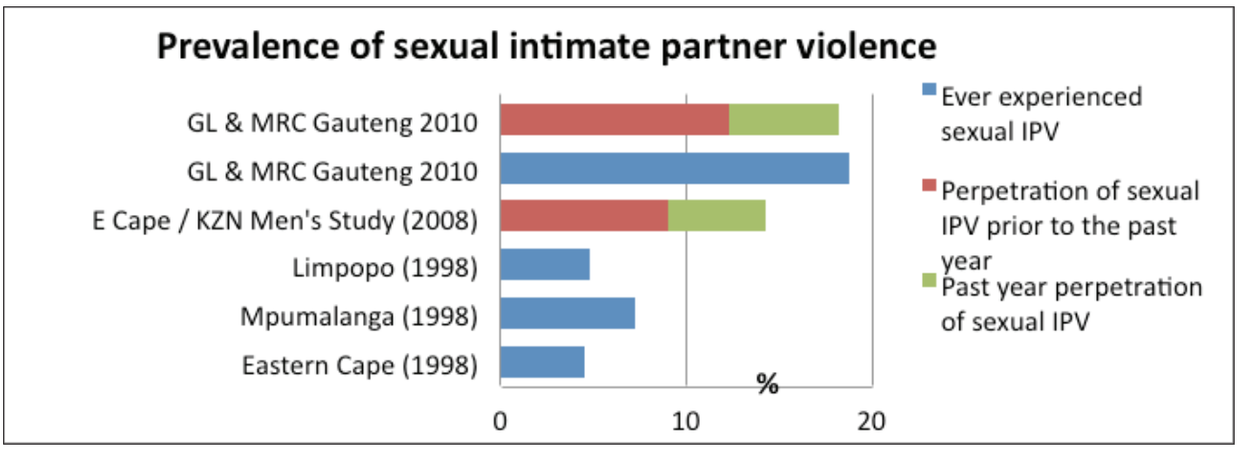

Figure 2: **Prevalence of women's experiences of sexual IPV and men's reports of perpetration in the past year, prior to the past year and in lifetime by province**

1.1.3 Emotional and economic intimate partner violence

Several studies have asked women if they were economically or emotionally abused in the past 12 months or ever. Emotional abuse was assessed as women being insulted, belittled/humiliated, scared, threatened, stopped from seeing friends or their partner boasting about, or bringing, girlfriends home. For economic abuse the questions asked whether a woman was not given money for household use when the partner had it, whether the woman or child was forcibly evicted from their accommodation with their partner, whether the partner took her earnings, or forbade her from working or earning.

Between one in three women reported experiencing emotional IPV.
One in two women reported economic or emotional IPV.

Figure 3 presents data on the proportion of men that reported perpetrating and women who disclosed experiencing emotional and/or economic violence in the past 12 months and ever. Between one in three women reported experiencing emotional IPV and one in two women reported economic or emotional IPV. Over two-thirds of men reported ever perpetrating emotional or economic IPV.

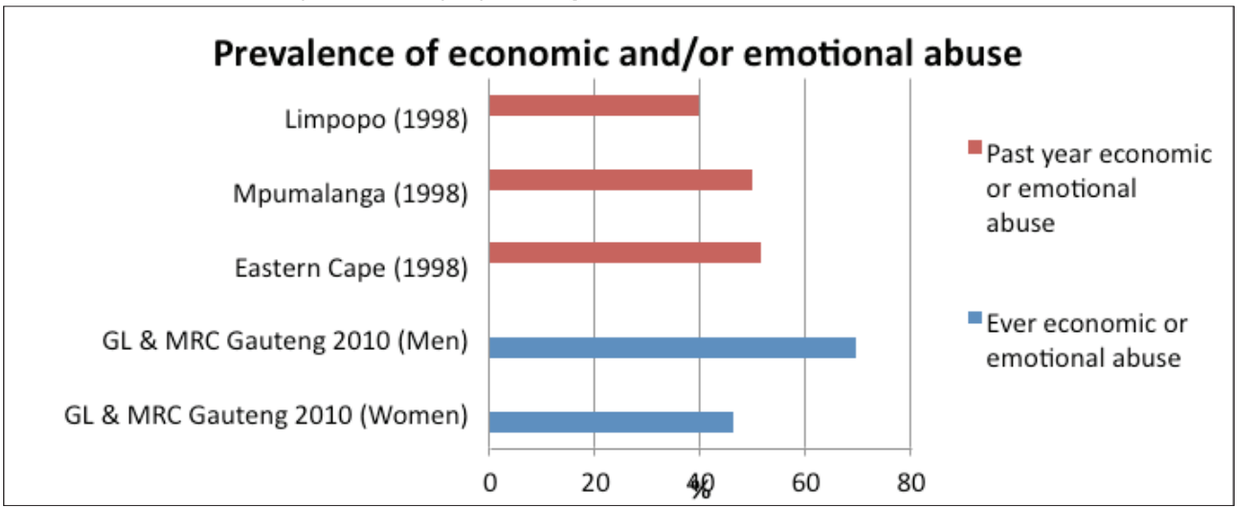

Figure 3: Prevalence of emotional and/or economic IPV in the past year and ever by province

1.1.4 IPV by demographic category

This section discusses differences in prevalence in different groups of the population. It does not seek to address causality. Table 2 shows prevalence of physical partner violence victimisation and perpetration in the past 12 months across the different sections of the population who responded to the Gender Links/MRC 2010 study in Gauteng[22] and among men responding to the MRC's study in the Eastern Cape and KwaZulu-Natal (2008).[23]

Age

Among women, there was some variation in prevalence between age groups, which may in part be explained by the small sample size in some age groups. Overall there was no evidence of a decline in the proportion of women reporting IPV exposure in the past year until the age of 55. None of the (n=63) women interviewed after 55-years-oldhad experienced IPV.[24]

Both studies that interviewed men found that past year violence perpetration was more commonly disclosed by younger men, while perpetration of IPV declined markedly in men over 40. The decline in IPV seen in older women generally corresponds with the decline in perpetration reported by men, although at all ages women report more violence experienced from a partner than men report perpetration and this may reflect a desirability bias in men's reports.

Race

The different study populations all exhibit somewhat different race patterns, but none of these differences are statistically significant.

Education

Women who had secondary schooling but had not completed matric or studied further were most likely to have experienced past year violence. Having only primary schooling and having tertiary education were relatively protective. This U-shaped pattern has been seen across a range of studies, including in the Three Province Study.[25] From the two studies of men, particularly the larger one from the Eastern Cape and KwaZulu-Natal, there is no trend by education.

Income

Women on a middle level of income (R2,000-5,000 per month) were most likely to have experienced past year violence. Those with higher or lower earnings were relatively protected. Among men the two studies had different patterns, and both showed statistically significant differences which persist after adjusting for race. This suggests there is currently no clear pattern of past year perpetration by income group. It is notable that there were too few men and women with very high earnings in this study to be able to comment on the prevalence in that category.

[22] Machisa et al, 2011
[23] Jewkes et al, 2009
[24] Machisa et al, 2011
[25] Jewkes et al, 2002

Table 2: Proportion of men and women in each category who had perpetrated or been victims of physical partner violence in the past year

Table of the proportion of men and women in each category who had perpetrated phyiscal partner violence in the past year (men) or experienced it (women)			
	Past 12 months (Gender Links/MRC 2010, Gauteng)		Past 12 months (E Cape & KZN Study, 2008)
	Victimisation	Perpetration	Perpetration
	%	%	%
Age: 18-20	10	14.3	8.1
20-24	17.8	13.6	12.5
25-29	18.6	1.6	13.7
30-34	14.6	12.5	11.3
35-39	20	10.2	7.8
40-44	7.9	4.3	5.5
45-49	9.3	0	5.3
50-54	18.9	3.5	
55 and over	0	2	
Race: African	13.1	6.6	10.5
Coloured	21.4	n/a	16.2
White	10.5	11.4	4.2
Indian	n/a	n/a	7.5
Education: primary schooling	8.8	3.7	11.2
secondary schooling	18.5	7.6	10.4
Matric completed	11.6	8.9	10
Any post-matric education	12	3.5	12.4
Monthly Income:			
Under R2000	12	7.1	16.7
R2001 - R5000	18.8	6.6	13.9
R5001 or more	7.1	9.2	3.8

1.1.5 Sexual violence against non-partners

Victimisation

Machisa et al reported prevalence of women's disclosure of rape by men.[26] Levels of rape victimisation were measured by asking whether:

(5) A man (who was not a husband or boyfriend) had forced or persuaded them to have sex against their will;

[26] Machisa et al, 2011

(6) They had been forced to have sex with a man when they were too drunk or drugged to stop him;

(7) They had been forced or persuaded to have sex with more than one man at the same time.

The final question is an indicator of gang rape.

An additional 1.8% had experienced an attempted rape, when a man had tried to force them but had not succeeded. Furthermore, 4.2% of women had been raped when drunk or drugged, 1.6% of women disclosed gang rape, and almost 5% of women had been raped by a non-partner on more than one occasion.

Overall, 12.2% of women disclosed that they had been raped by a man who was not their husband or boyfriend i.e. a family member, stranger or acquaintance.

Most women reported being raped for the first time when they were aged 17 or younger (64.7%); 19.6% were aged 18-24, 15.7% were aged over 24 years. In the past year, 1.4% of women reported having been raped by a stranger or acquaintance.

Non-population based research provides estimates in the same range. Dunkle et al's study of women in antenatal care in Soweto (n=1395), found that 7.9% of women had been raped when they were an adult (15 years and older) by someone who was not a partner. In the rural Eastern Cape, 5.4% of women aged 15-26 enrolled in the Stepping Stones study (n=1365) had been raped by a non-partner and 22.1% had experienced attempted rape.[27]

Perpetration

In the Gender Links/MRC Gauteng study,[28] perpetration of rape of a woman who was not a partner was assessed by asking men the same three questions, whether they:

(1) Had forced or persuaded a woman who was not a wife or girlfriend to have sex against her will;

(2) Had forced a woman to have sex when too drunk or drugged to consent;

(3) Had forced or persuaded a woman to have sex with themselves and another man at the same time (gang rape).

Overall 31.0% of men disclosed having raped a woman who was not a partner, and 12.7% had attempted to rape a non-partner. Among these findings, 25.6% disclosed that they had forced or persuaded a woman who was not a wife or girlfriend to have sex against her will,14.4% had forced a woman to have sex when she was too drunk or drugged to refuse and 6.9% had engaged in gang rape. These statistics are higher than the other available estimate which is from the study of men in the Eastern Cape and KwaZulu-Natal in which 21% of men disclosed perpetration of sexual violence against women who were non-partners.[29]

Overall 31% disclosed having raped a woman who was not a partner, and 12.7% had attempted to rape a non-partner.

[27] Jewkes et al, 2008
[28] Gender Links and MRC, 2012
[29] Jewkes et al, 2006

Data from non-population based research on non-partner rape perpetration is available from the Stepping Stones study.[30] At baseline, 16.3% of the men interviewed had ever raped a non-partner or engaged in streamlining (gang rape), among these 12.6% had raped a non-partner and 13.9% had done streamlining.[31]

1.1.6 Intimate partner femicide

Worldwide, 3.5% of homicides are committed by an intimate partner. This proportion is six times higher among female homicides or femicides (38.6%) compared to male homicides (6.3%).[32]

In South Africa, more than half of the women murdered in 2009 (56%) were killed by an intimate partner.[33] South Africa's intimate femicide rate was lower in 2009 than in 1999,[34] (2.0/ 100,000) but it was more than double the rate in the United States. Since no perpetrator is identified in over 20% of murders, this statistic is very likely underestimated. Girl child murders represented 25% of all cases in 2009 and child rape homicide almost exclusively affects girl children.[35]

In South Africa, more than half of the women murdered in 2009 (56%) were killed by an intimate partner.

These studies alert us to a problem about which very little was known. However, these studies have a number of limitations and the data needs to be interpreted with this in mind. The sample sizes for both studies were adequate to calculate population incidence rates, however it was not possible to draw comparisons between study years, especially for subgroups, and there is a substantial risk of not discovering true underlying differences in the years. That said, it is unlikely that the figures reported underestimate female homicide rates in South Africa, particularly given the proportion of cases found at mortuaries with missing data (18.5% in 1999 and 22.9% in 2009).[36]

1.1.7 Child sexual abuse

The Department of Women, Children and People with Disabilities completed a study on Violence against Children in 2012. The study outlines the extent, nature and manifestations of violence against children and identifies the risks and consequences at global level. The report also outlines important prevention and protection interventions that can be used to ensure that children are protected and that violence is prevented. Table 3 provides a summary of South African studies that provide self-reported measures of sexual victimisation or first forced sex. Levels of child abuse reported in these studies range from 7.3%[37] to 39.1%[38] for girls and are lower for boys. However the definitions used in the different studies are not the same.

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30 Jewkes et al, 2008
31 Jewkes et al, 2006
32 WHO, 2013
33 Abrahams et al, 2013, study based on a comparison between the results of two South African national studies of female homicide with similar sampling in 1999 and 2009, and analysis of victim data from 38 mortuaries' autopsy reports, and perpetrator data from police interviews.
34 Matthews et al, 2004
35 Abrahams, et al 2013
36 Ibid.
37 Dunkle et al 2005
38 Jewkes et al, unpublished manuscript

Table 3: Levels of sexual victimisation in childhood and forced first sex in South Africa

Author/year	Sample	Location / size	Study design	Sexual victimisation by a man %
Jewkes, Dunkle, Nduna, Shai, Puren (2010)	Adult men and women aged 18+	Eastern Cape (rural) 1,367 male and 1,415 female; 2003-4 data	Baseline survey for a cluster randomized controlled trial of behavioural intervention	39.1% women and 16.7% men had experienced contact sexual abuse; 18.8% of women and 1.4% of men had been tricked or forced the first time they had sex when aged under 18 years
Jewkes, Vundule, Maforah & Jordan (2001)	Pregnant and non-pregnant young women aged <19 years	Western Cape: 191 cases 353 controls; 1995-6 data	Case (pregnant) control (non-pregnant) study	31.9% pregnant women and 18.1% non-pregnant women had experienced forced first sex
Dunkle, Jewkes, Brown, Gray, McIntryre, Harlow (2004)	Women aged 18+	Gauteng (n=1366); 2001-2 data	Antenatal clinic cross-sectional survey	7.3% had experienced forced first sex; 8% had been raped as a child (before age 15)
Machisa et al 2011	Women aged 18+	Gauteng (n=488); 2010 data	Population-based survey	8.5% had experience forced first sex;24.4% had experienced unwanted sexual touching or rape before age 18

Forced first sex was consistently measured in all the studies through the question 'Which of the following statements most closely describes your experiences the first time you had sexual intercourse?' and includes 'I was raped' and 'I was forced' as response options. In the Eastern Cape study the response 'I was tricked' was also included, which partly explains the higher prevalence of forced first sex, as 11.8% women reported they had been tricked. Qualitative research has indicated that 'trickery' really amounts to non-physically violent coercion.

The figures in these studies are similar to national and international studies in sub-Saharan Africa. For example, in a Tanzanian national survey of children aged 13 to 24 years 27.9% of females and 13.4% of males reported experiencing at least one incident of sexual violence before turning 18,[39] while in Namibia, 21% of women reported their first sexual experience as forced before the age of 15[40] and a third of young women in Swaziland reported sexual abuse before 18.[41]

1.1.8 Summary

This section has shown that even though data from high quality population-based research on VAW is limited, available prevalence data tell the same story and give a picture of the scale of the epidemic that is reliable.

It is essential that future investment in VAW surveillance prioritises both research quality and adherence to international best practice.

[39] UNICEF/CDC, 2011
[40] Garcia-Moreno, et al, 2005
[41] Reza et al 2007

However, there is no national research mechanism for VAW surveillance although such mechanism would be critical to monitor and evaluate efforts to reduce VAW. There have been many attempts to develop national indicators for VAW, but they have not been successful. More effort to create a shared set of indicators to monitor levels of VAW in South Africa is urgently needed.

Further research to generate population-based indicators on VAW in South Africa must use a gold standard measure. The internationally recommendations for low and middle income countries is to use the measure of victimisation from the WHO's Multi-country Study on Women's Health and Domestic Violence and the measure of perpetration from the UN Study of Men's Use of Violence in Asia and the Pacific.

Studies must follow the ethical and safety guidelines of the WHO for research on women's experiences of violence and of the Sexual Violence Research Initiative (SVRI) for research on men's perpetration of violence.[42] Interviewers need to be carefully selected, excluding those with strong patriarchal views or substantial unprocessed personal experiences of violence. They must be trained for more than a week and training must include sessions addressing personal experiences of violence and providing psychological first aid to distressed participants. During fieldwork, interviewers must have referral details to give research participants and must receive debriefing and support. In addition data on sexual violence perpetration should be gathered using a self-report mechanism.

Key facts

- Overall between 19%-33% of women have ever experienced physical partner violence, but in some population subgroups it may be as high as one in two women.
- Perpetration by men is more commonly reported and population-based studies have reported this among 40%-50% of men.
- Sexual violence against intimate partners is less common than physical violence and very commonly accompanies it.
- The better population-based studies show the prevalence of having experienced SV to be nearly 20%.
- Men's perpetration of SV whether against a partner or non-partner has been reported by between 28-37% of adult men in the two high quality population-based studies referred to in this section. Non-partner SV is particularly common, and the high prevalence of reporting of streamlining or gang rape is also notable.

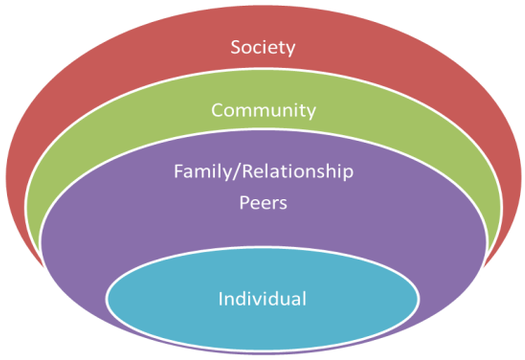
Current available research shows that VAW is highly prevalent in South Africa and interventions to prevent it are urgently needed.

1.2 Analysis of the risk factors for IPV and SV in South Africa

In order to prevent violence, it is important to understand the circumstances and the risk and protective factors that affect its occurrence. Some structural drivers of VAW, such as youth unemployment, are already on the government's development agenda for other reasons. Other factors lie within the mandates of NGOs or government departments working on VAW responses and prevention, and lack sufficient effective intervention. They are presented here.

[42] Jewkes R, Dartnall E and Sikweyiya Y, 2012 ; Ellsberg M, HeiseL, 2005.

Figure 4: Ecological model



Research shows that while interpersonal violence and sexual violence occur between individuals, they are influenced by factors that pertain at many different levels within society. The World Health Organisation uses an ecological model to illustrate the different levels at which different factors operate in driving the problem of VAW (**see figure 4 above**). The model has individual, peer, family or relationship, community and societal levels.

Many of the risk factors in the ecological model operate at multiple levels. For example, social norms around masculinity are primarily generated at social level and sustained at community level, but are also reflected in norms among family and peers and impact on an individual's ideas, expectations and behaviours. Furthermore, many factors are interrelated. Thus social norms around masculinity often single out an ability to drink heavily as a marker of tough and strong manhood. Consequently an individual man's alcohol abuse is likely to be driven by ideals of manhood as much as by factors such as pricing, advertising and availability.

The model demonstrates that a comprehensive response to VAW prevention requires intervention at multiple levels.

The ecological model further shows that there is no single causal pathway to being a perpetrator or victim. Factors operating at various levels combine to establish the likelihood of occurrence and no single factor is sufficient or necessary,[43] as individuals respond to exposure in different ways. For example, the experience of rape during childhood very greatly increases the chance of boys becoming rape perpetrators as adults, but many of those who are raped as children will not become perpetrators later in life.

Global understanding of VAW risk factors has been extensively informed by research and research synthesis undertaken in South Africa. When measured by the volume of original research, South Africa is a world leader on VAW-associated factors and causation, in both quantitative and ethnographic research.[44]

The risk factors for women experiencing VAW and men perpetrating VAW are presented in Table 4 below – these have been established through research in South Africa. Studies of victimisation have largely focused on physical and sexual IPV, but the studies on perpetration have included analysis of risk factors for non-partner rape perpetration.

[43] Heise, 2011

[44] South Africa was one of the first countries of the global South to: 1) Publish an analysis of factors associated with VAW victimisationvictimisation based on interviews with a large population-based sample of women (Jewkes et al 2003); 2) Publish on factors associated with IPV perpetration from a large sample of adult men (Abrahams et al 2004) ; 3) Publish on factors associated with rape perpetration based on a large population-based sample of adult men (Jewkes at al 2011);
4) It is the only country to have information from a longitudinal study of men on rape perpetration (Jewkes et al 2012).

Table 4 Risk factors for experiencing and perpetrating VAW

Perpetration by men	**Victimisation of women**
Individual level	
Level of social power: • Social power limited but not the lowest (relatively less poor, having some tertiary education)	**Level of social power**: • Limited educational power (no post-school education) • Limited social power (lacking social support)
Exposure to maltreatment: • Childhood abuse (physical and emotional) • Being a victim of sexual violence • Witnessing abuse of mother by her partner	**Exposure to maltreatment**: • Childhood abuse (physical and emotional) • Witnessing abuse of mother by her partner
Mental disorder: • Depression • Personality disorder (psychopathic traits)	**Mental disorder:** • Depression
Substance use: • Alcohol abuse • Illicit drug use	**Substance use**: • Drinking alcohol
Conservative ideas about gender: • Conservative ideas on gender relations • Ideas of sexual entitlement	**Conservative ideas about gender:** • Conservative ideas on gender relations
Acceptance of violence of other types: • Raped a non-partner (risk for physical and sexual IPV) • Physical IPV (risk factor for non-partner rape) • Gang member • Perpetrating bullying when at school • Susceptible to peer pressure	**Acceptance of violence:** • Acceptance women sometimes deserve to be beaten by a partner
Relationship level	
Sexual risk: • Transactional sex with a casual partner or once off • Multiple sexual partners • Having more frequent sex (among youth)	**Sexual risk:** • Multiple sexual partners
Conflict in relationship: • Poor communication skills	**Conflict in relationship:** • Frequent conflict between partners • Poor communication skills
Community Level	
• Subculture of young men hanging out in groups or gangs • Community views that subordinate women	• Community views that subordinate women
Societal Level	
• Conservative views about gender prevalent at high levels in society • Male sexual entitlement widely expressed across society	• Conservative views about gender prevalent at high levels in society • Male sexual entitlement widely expressed across society

It is impossible to isolate a single cause for perpetrating or being victims of VAW. For example, the available data show that having multiple partners is a risk factor, but having multiple partners alone cannot be considered as a necessary and sufficient condition for victimisation and perpetration of VAW.

The sections below present the evidence on the risk factors of VAW in South Africa, starting with the societal factors and moving down the WHO ecological model. Where possible, the pathways linking the risk factor to the violent act are explained. As societal-level factors greatly influence the other levels, they are presented in more detail, especially as they relate to the unequal position of women in society. These factors are not easy to isolate and not considered enough in prevention interventions, but they have been widely researched in South Africa.

1.2.1 Societal-level factors

Two norms pertain across South African society and critically influence the problem of VAW. These are the ready use of violence across social groups and institutions to assert power, achieve power or punish; the second are patriarchal gender norms which, notwithstanding their Constitutional rights, position women and girls as having lower social value, power and status to men and boys.

Social norms supportive of violence

VAW reflects in part the propensity to use violence in social relations across sectors of society. South Africa has a history of state violence, political violence and the use of violence in all forms of social relations. This is shown in the on-going controversy around the police's shoot to kill policies, high levels of gun ownership and use, the continuing use of corporal punishment in schools 15 years after it was made illegal, sporadic vigilantism against township criminals, great resistance to proposals to outlaw beating of children, use of violence by health professionals against patients, and the use of violence in social relations in homes and neighbourhoods. In addition, premature injury mortality in South Africa is twice the global average and is driven by interpersonal violence, which is the leading type of injury mortality and constitutes 46% of total injuries.[45] South Africa has the third highest homicide rate in the world.[46] Violence is also fuelled by high rates of poverty and unemployment and income inequality, childhood exposure to violence, and weak structures to prevent violence and prosecute perpetrators.[47] In this context, the ready use of violence by men against women is part of a national pattern of ready resort to the use of violence.

Patriarchal gender norms

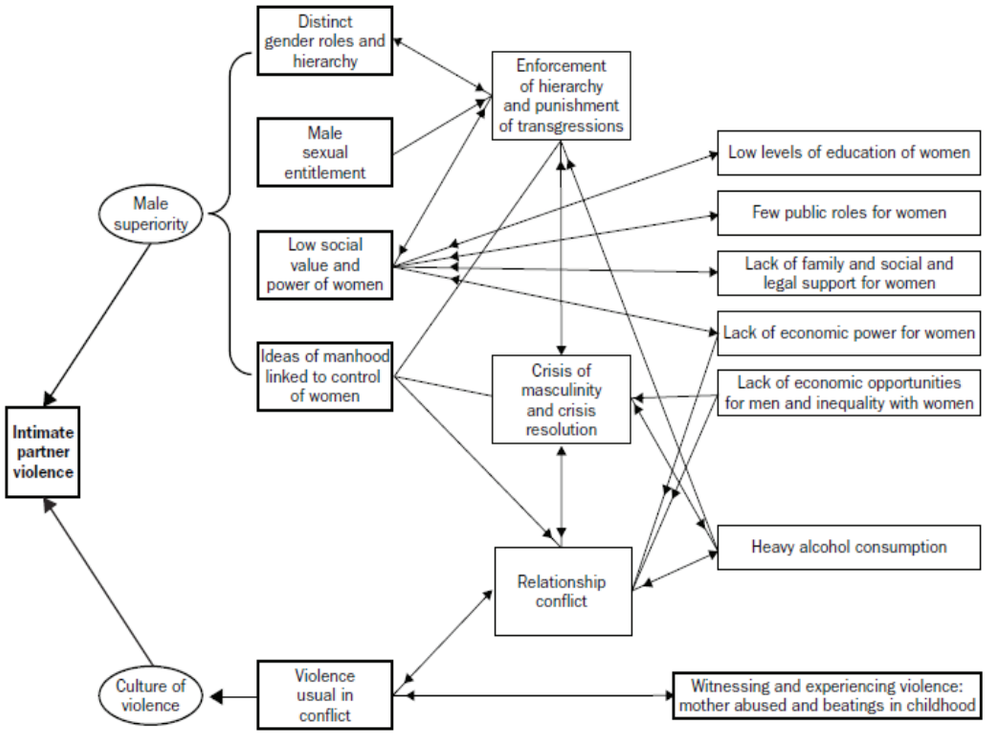
South Africa is a patriarchal country, where men are positioned as superior to women and are accorded more power. This operates at an interpersonal level as well as through social institutions including the police and courts. A stark illustration of differential social values is shown by the research finding that girl children who are killed are three

As a result only 6 in 100 rape cases opened with the police end in conviction.

[45] Norman et al, 2007
[46] Cuiker, 2006, as quoted by Abrahams et al, 2010
[47] Seedat, et al., 2009

times more likely than boys to be the victims of child abuse and neglect. Although the Constitution and legal reform post-1994 has strengthened the rights of women, most are still not able to realise those rights because there is not yet a parallel equity in intimate relationships, families and communities. This is reflected in social institutions and affects expectations of accountability and impunity for violence. The subordinate position of women in rural areas is most clearly illustrated by the requirement in Traditional Courts that women be represented by men. Although these courts do not hear rape cases, the very low conviction rate in the courts that do reflects the resourcing levels given to investigating VAW, and the pressure put on women to withdraw cases (or lack of support to pursue them). There is also evidence that gender attitudes of court officials, expert witnesses, prosecutors and the police negatively influence case outcomes.

The impact of patriarchal norms on interpersonal relations is also seen in the propensity for women and girl victims of rape to be[48] blamed for 'causing' it through their dress or demeanour, and the reluctance to hold men and boys legally accountable for their sexual violence through pressing cases. The lower social value of women enables them to become victims of violence without men seriously expecting to be punished. It also sets up expectations of women's subordination to men, which may be an immediate cause of violence if women resist this lower social position.



Source: Jewkes R. 2002.

Figure 5 Risk factors for Intimate Partner Violence

Patriarchal social norms also influence the ideals of masculinity that are seen as most desired and which are recognised across society, even by men who do not themselves want to attain them, or attain all of them. To quite a substantial extent, these norms pertain to all racial groups, ages and

[48] Vetten et al, 2008 (text box: 6 in 100 rape cases opened with the police end in a conviction).

social classes. Thus there is a social norm of an ideal South African man who is tough and strong and ready to defend his honour with force if necessary. He is heterosexual and shows this by proving his sexual attractiveness to women, for example by having many partners. He is head of the family or home, and is dominant over all women[49] and demonstrates that he is in control of 'his' women. This social ideal of masculinity impacts on all the levels of the ecological model and is often expressed through other risk factors, as shown in the discussion below.

Figure 5 above depicts the factors at play in IPV and shows their complexity and the linkages between them.

1.2.2 Community level factors

Poverty and gangs

Men who live in poverty are much more likely to become involved in the anti-social misogynistic subcultures in which VAW is common.

A strong connection between gang membership and violence perpetration is found worldwide. Belonging to a gang is fertile ground for the expression of the dominant ideals of masculinity that will shape men and boys' identities. Negative early childhood experiences influence feelings of insecurity, which in turn greatly increase the likelihood that as boys grow into men they will pursue masculinities that emphasise toughness and control over others, including women.[50] The use of IPV and rape of non-partners has been found to be associated with other delinquent behaviours, including having been or currently being in a gang in South Africa.[51]

The use of IPV and rape of non-partners has been found to be associated with other delinquent behaviours, including having been or currently being in a gang in South Africa.

Rape perpetration is more common among men who are relatively advantaged, or have more power, but live in poor communities. Based on research with a large sample of rural young men, Jewkes (2006, 2011) found that rape perpetrators within poor communities had less poor backgrounds, earned incomes and had educated mothers, which gave them "a sense of entitlement" underpinned by the dominant conception of masculinity which emphasises control over women.[52]

In South Africa, research on IPV has shown that it is not the absolute level of income that predicts the use of violence, but instead conflicts over household finances underpinned by issues relating to women's power and male identity.

[49] Morrell et al, 2012
[50] Jewkes, 2013
[51] Jewkes, 2011 and 2012
[52] Jewkes, 2011 and 2012

1.2.3 Relationship level factors

Conflict/lack of communication within relationships

Global and South African evidence reveals that IPV is more common in relationships where there is more conflict. Part of the explanation is that conflict often escalates, especially if social skills are poor, and violence may be used to gain power within the argument. Conflict in relationships is often about money, especially when men have money and do not give women enough to run the home, and jealousy. Poor communication within a relationship is another factor contributing to IPV.[53] Research shows that interventions to strengthen communication skills result in decreased use of violence. Furthermore, because of the violent context, women victims of IPV face difficulties in communicating with their partners on most topics, and especially around sex, HIV/STIs and condom use, as communication attempts could lead to abuse.[54]

Having multiple partners

Having multiple partners both creates risk for women of experiencing IPV and rape, and is a response to IPV. It creates risk because jealousy is a very well documented trigger to IPV and can lead to gang rape.[55] It is also a response to IPV in that women often describe how violence results in an end to the love in a relationship; despite this, they may not actually end the relationship, sometimes because of fear, but rather take a new partner in addition. This in turn can result in spiralling violence.[56] On the other hand, men's multiple partnering increases the risk of violence if this is a source of conflict in the relationship. Furthermore, men having multiple partners reflects a striving to embody the ideal and practice of South African hegemonic masculinity, which is based on control of women and through this, legitimises the use of violence against women.[57]

1.2.4 Individual level factors

Biology (perpetration)

There is evidence that genes are important in the development of aggression. The genes concerned have been shown to operate through pathways that are activated in the presence of exposures in the social environment, for example to trauma and abuse in childhood.

There is very limited research on the role of genetics in sexual aggression, but the evidence suggests that there may be a genetic element that increases the propensity to rape, but it accounts only for a small part of the risk of raping. The evidence on the impact of testosterone on the likelihood of sexual aggression is weak and inconsistent.[58]

[53] Fox et al, 2007
[54] Fox et al, 2007: qualitative study examining the intersections of risk for IPV and HIV infection in South Africa; based on interviews with 18 women seeking support from the NGO POWA.
[55] Jewkes R, et al, 2006; Wood, K, 2005; Jewkes R. et al, 2002.
[56] Jewkes R, Morrell R, 2010.
[57] Morrell R et al. 2013.
[58] Jewkes, 2013

Social power (derived from education, economic, networking levels)

Social power, generally low or lower power, is very important as a risk factor for perpetration of violence and victimisation. Although a proportion of men from all educational and economic power levels is violent against women, the greatest risk lies among those who have intermediate levels of power. For example, men who have some tertiary education are more likely to be sexually violent than men who have very low levels of education, or men who have completed qualifications. Part of the reason for this greater likelihood of violence is that men who have some resources or education may more acutely perceive themselves as inadequate because they do not have enough to acquire the material trappings of success they desire, or else may have heavy expectations placed on them by family members who require support that they cannot readily meet. Conflict in relationships resulting in violence may be fuelled by a sense of inadequacy. The risk of rape has been discussed above.

For women, low social power is linked to violence vulnerability. Thus, women who have not completed school or without tertiary education are more likely to be abused, as are women who are stigmatised in some way. Poverty traps women in violent relationships and increases their risk of being attacked during daily activities such as collecting firewood or water in rural areas, or walking to work.[59]

Women who lack social networks of support, who have no one to talk to about violence in their lives and have limited options for leaving abusive relationships are much more likely to experience abuse and are less able to avoid repeated abuse experience.[60] Fox et al's qualitative research study showed how male dominance and control in relationships is reinforced through social norms that encourage women to endure abusive situations and validate male sexual prowess.[61] The study noted that the "social environment of silence, male power, and economic constraints enable abuse to continue". Some women had encountered expectations that a woman should endure an unhappy relationship, with, in some instances, pressure from elders, family, and community members.

Exposure to child maltreatment

Child maltreatment encompasses exposure to physical, sexual and emotional abuse and witnessing abuse of one's mother. Physical punishment is pervasive among boys in South Africa and commonly used among girls. It occurs across a spectrum of severity to forms that amount to abject cruelty, such as burning a child's hands or beating them with a saline-soaked belt. Emotional abuse and neglect stems from the very low status of children. It can result in considerable psychological distress, even when this is not intentional, for example not revealing the identity of a biological father or allowing a child to be affected by poverty aggravated by not providing maintenance, or being too drunk or focused on a new partner to care for a child properly. Social and financial abandonment of children by their fathers is by far the most highly prevalent and serious form of child abuse.[62]

Genetic components of violence are not themselves amenable to intervention, but those genes that are trigged by hardship and trauma are amenable, thereby highlighting the importance of preventing childhood adversity.

[59] Jewkes & Abrahams, 2001.
[60] Jewkes et al, 2008
[61] Fox et al, 2007, based on qualitative interviews
[62] Mathews S and al, 2011

Having witnessed abuse of one's motheris a well-researched risk factor for IPV victimisation and perpetration, and is consistently associated with it. Witnessing this abuse impacts on social learning about intimate relationships and leads children to consider violence to be normative in gender relations – girls learn that subordination to males and experiencing violence are part of being a woman and boys learn inequitable conceptions of masculinity.

Exposure to physical, sexual and emotional abuse in childhood results in children having low self-esteem, higher levels of aggression, being more impulsive and having lower levels of empathy. Further it impacts negatively on their capacity to form secure attachments. Exposure to sexual abuse during childhood is a risk factor for perpetration later in life, and may operate also through social learning. It is one of the most researched risk factors for rape perpetration.

In South Africa, evidence links exposure to child maltreatment with IPV.[63] More than half of the adult women who faced domestic violence had experienced violence in childhood and more than one-third had witnessing their mothers' abuse in the Three Provinces study.[64] In addition, another research showed that almost one quarter (23.5%) of men reported witnessing abuse of their mother, and having witnessed such events was associated with men's later use of physical violence against their partner, among other violent behaviours.[65]

More than half of the adult women who faced domestic violence had experienced violence in childhood and more than one-third had witnessed mother's abuse.

The evidence suggests an intergenerational cycle of violence, where male victims may become perpetrators and female victims may face later re-victimisation.

In South Africa, 17.2% of the men who had raped a woman had been raped in their childhood, as opposed to 6.3% of the men who had not raped.

Gender inequitable attitudes

Even within a cultural context of patriarchy, men and women differ in their personal views on gender equity.

A South African study showed that men perpetrating rape had "less equitable views on gender relations and were more adversarial in their views about women". They had many more sexual partners and were more likely to have had transactional sex.[66]

The clearest expression of the role of gender inequitable attitudes in rape perpetration is the finding that the most commonly reported motivation among the men who had raped was ideas stemming from sexual

[63] The statistics presented in the box are extracted from: Abrahams, 2005, based on a survey of 1,368 randomly-selected male municipal workers in Cape Town.

[64] Jewkes et al, 2002, based on a cross-sectional study conducted in 1998 with 1,306 women in three provinces of South Africa.

[65] Abrahams, 2005, based on a survey of 1 368 randomly-selected male municipal workers in Cape Town.

[66] Jewkes, 2011: a cross sectional study among 1 737 South African men aged 18-49.

entitlement.[67] [68]Other motivations for rape were anger or stemmed from the intent to punish. The social acceptability of male sexual entitlement is also reflected in the commonly expressed ideas that women or girls are responsible for their own rape (for example by provoking male desire) and the high level of communities' stigmatization of rape victims.

Conservative ideas about gender relations and a belief that men's use of violence is legitimate in some circumstances or excusable is also associated with women's experience of VAW.

Conspicuous performance of heterosexuality and objectification of women

The dominant ideal of masculinity in South Africa emphasises conspicuous performance of heterosexuality, which is fuelled by competition between men. Men are supposed to be sexually desirable to women (and thus have many partners) and to prove this by winning over other men's partners. They are also supposed to be ever ready for sex and one demonstration of this is the propensity for having transactional sex, which is for the most part sex which is disengaged from an emotional relationship. When measuring indicators such as having many lifetime partners or having transactional sex, men who do so are much more likely to be violent towards women.[69]

The connections between having more partners and violence are four-fold. Firstly, male desire for many sexual partners stems from pursuit of the underlying ideal of masculinity which also emphasises dominance and control over women. Secondly, men who have multiple partners may have a more conflicting relationship with their main partner as a result – this is either due to her jealousy or because it may financially impact on her and her children. Thirdly, men who see women as something to be conquered in order to prove their superiority over other men may feel acutely vulnerable to losing their own women, and thus may be very jealous and suspicious and this may cause conflict which results in the use of violence as a means of attaining control. Finally, men who expect women to submit to their dominance may simply be more ready to use physical force to achieve this. Research supports all of these explanations.[70]

The connection between men's violence and transactional sex partly stems from the underlying masculinity connecting these behaviours, but it is also apparent that men may see themselves as entitled to sex from women because they provide drinks or transport or money for small things.[71] Violence, whether sexual or physical, very often is the consequence of the expectation of sex as a right which women may resist. Transactional sex is characteristically distinguished from sex work by a lack of upfront negotiation on price, therefore the woman involved may not perceive the man's entitlement to sex in the same way that he does.

Among women, having more than one partner in the last year is associated with a greater risk of partner violence.[72] This is likely to be partly because women are more likely to leave men who are violent or to take another partner for 'love' or revenge, which may then make them vulnerable to violent responses of jealousy from their partner.

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[67] Jewkes et al, 2008
[68] In other words the idea that if a man wants sex or wants to see if he can make a woman or girl have sex with him that makes it acceptable for him to force sex irrespective of what the woman or girl feels.
[69] Morrell et al, 2012
[70] Ibid.
[71] Ibid.
[72] Jewkes, 2002

Personality disorders

Early exposure to abuse impacts on brain development in boys and thus impacts on personality. Antisocial personality disorders are associated with VAW perpetration, both rape and IPV. South African research has highlighted the connection between antisocial personality traits and killing of intimate partners. South African research in the general population on men who rape shows strong associations with dimensions of psychopathy and lower empathy.[73] These findings are entirely in keeping with international literature.

Depression

There is evidence that men who use violence against intimate partners are more likely to be depressed. Research shows that depression may cause men to become violent, but it is also an emotional response to having used violence and the negative impact that this has on a relationship. Feelings of hopelessness may exaggerate irritability in men who are inherently more irritable and prone to anger, and as a result they may use violence more readily.

In South Africa, a bi-directional association between IPV victimisation and perpetration and depression was evidenced: this means that women who showed depressive symptoms were more likely to be victims of IPV and women who were victims of IPV were more likely to develop depressive symptoms. IPV was also associated with incident suicide attempts among women.[74]

Alcohol abuse

In South Africa, there is evidence of the association between drinking and greater odds of men perpetrating physical IPV[75] *and sexual assault.*[76]

In addition, women who drink are more likely to become victims, as well as less likely to report the violence to the police. Alcohol is often a source of conflict, especially when scarce resources are spent on it instead of being used to provide for the family. Being drunk leads to dis-inhibition, poorer problem-solving abilities, increased sexual risk-taking behaviours, enhanced emotional responses, and less thought given to consequences. In addition, alcohol consumption may give men permission to express culturally-bound social norms that condone male dominance over women.[77]

Population surveys in South Africa show that less than half of men drink alcohol and the proportion of women who drink is significantly less. However, those who drink do so to alarmingly high levels, with particularly heavy drinking during weekends.[78] The culture of very heavy drinking is driven by ideals of masculinity that associate male toughness with an ability to drink heavily. The challenge for VAW prevention is to reduce drinking to excess.

[73] Ibid.
[74] Nduna et al, 2012. The study investigated the association at two points in time, with 1,002 female and 976 male volunteers. Prevalence of depressive symptoms was 21.1% among women and 13.6% among men.
[75] Townsend et al., 2010
[76] Simbayi et al., 2004 as quoted by Watt et al, 2012
[77] Watt et al, 2012
[78] Graham, et al., 2011, as quoted by Watt, 2012

Qualitative research by Watt et al has shown that in public places, such as bars, alcohol combines with the venue atmosphere to increase men's sense of power and this fuels aggressiveness towards women.[79] Alcohol particularly leads to violent behaviour by women who drink and to disputes between couples (including men reproaching their wives who drink, as it defies gender norms). The research also shows "how violence that occurs while drinking is quickly forgotten and dismissed, an attitude and practice that further condones violent behaviour". There is also evidence of men drinking to gain courage to beat their partner when they feel it is socially expected.[80] Alcohol is perceived as giving women the courage to defy traditional gender norms, which often leads to violence.[81]

Drug use

Research on rape has shown that men who have raped are more likely to use drugs. A prospective study among youth from South Africa's Eastern Cape concluded that 24% of all rapes would have been prevented if drug use had not occurred. However, in this setting the drug use was almost exclusively confined to dagga and it is very unlikely that the problem was a direct pharmacological effect of the substance. The links between drug use and VAW for the most part stem from the broader sociocultural context of drug use, particularly the fact that in many areas, especially rural areas, drug use occurs among men and boys who position themselves outside respectable mainstream culture in a subcultural space where illegal and antisocial activities are viewed as legitimate and where a glorified tough, misogynistic and violent masculinity is seen as an ideal.[82]

A prospective study among youth from the Eastern Cape concluded that 24% of all rapes would have been prevented if drug use had not occurred.

Individual propensity to use violence

Perpetrators of VAW are more likely to use violence of different types. For example, men who rape have been shown to be more likely to have been bullies at school, to have weapons, to have had an illegal gun and to fight with other men. Gang membership is also more common among men who rape.

1.2.5 Under-researched vulnerability factors

Men who are sexually violent very often target women or girls who are seen as having lower social status or power, because they perceived that they are less likely to be held accountable for their behaviour. Four groups of women of particular concern are: disabled women, migrant women, lesbians and sex workers. All four groups have limited access to support services and the criminal justice system. In addition, they can be considered easy targets, because of the cultural and community environments that fail to recognise their rights due to their impairment, homophobia, xenophobia or geographic and cultural isolation. Violence against these women can be considered as an exacerbated expression of inequitable gender norms and hegemonic masculinities, and the stigma against them constitutes a form of emotional abuse.

[79] Watt et al, 2012: qualitative research based on interviews with a total of 55 respondents (venue patrons and owners, both males and females) and structured observation in six alcohol-serving venues.
[80] Jewkes 2002
[81] Watt et al, 2012
[82] Jewkes, 2012

Disabled women and girls

Research on these groups is very limited. Anecdotal evidence suggests that women and girls with disabilities are at a higher risk of sexual violence than those who are non-disabled, and those with severe disabilities or mental illness could be particularly vulnerable. Types of abuse and violence experienced are both traditional and unique to people with disabilities and include abuse and neglect related specifically to their disability or to social isolation. Research conducted in Canada showed that women with disabilities had 40% greater odds of violence in the five years preceding the interview.[83] There is no population-based data on this in South Africa.

Migrant women

Migrant women may be particularly vulnerable too. The Gender Links MRC study in Gauteng found women who were not born in South Africa to have a substantially higher prevalence of lifetime exposure to physical or sexual partner violence.[84] It is unclear whether this reflected exposure after coming to South Africa or prior to or during migration. It is also possible that many immigrant women come from countries that have even more conservative social norms than South Africa and that this may increase their risk from their partner.

There is no survey data on risk associated with internal migration in South Africa. However qualitative research conducted by the International Organisation on Migration among others showed high levels of rape among women working on farms[85] as well as fear and experience of violence among women living in big cities such as Johannesburg[86] or Durban.[87] Anecdotal evidence also shows that cross-border informal traders may be sexually harassed or even raped by border officials, truckers or taxi drivers. Migration makes it difficult for migrant women to access support as they do not have the same network as they have at home, particularly new arrivals. In addition, they have difficulties accessing government support because they fear xenophobia and deportation, as they are often undocumented. Since they live on the verge of destitution as well, many women rely on their partners for obtaining goods and money, and can be compelled to endure domestic violence for survival. They tend to tolerate and prefer private violence over public violence, as they see it as "the only available option".[88] Finally, violence against women during the migration process is rife, as is the case with informal cross-border traders.

Lesbian women

There is considerable evidence that lesbian women, particularly in black townships, are increasingly targeted for rape. They are seen to epitomise a challenge to traditional male authority, because they are viewed as living outside a domain of male control. Thus the root cause of hate crime against lesbian women is to be found in dominant conceptions of gender relations that expect women to fall within a domain of male control

[83] Using a representative sample of 7,027 Canadian women living in a marital or common law union, this investigation examined the risk for partner violence against women with disabilities relative to women without disabilities, quoted in Brownridge, 2006.

[84] Gender Links and MRC, 2010

[85] International Organisation of Migration, 2009

[86] Munyewende et al., 2011: qualitative study based on in-depth interviews with 15 Zimbabwean women living in the inner city of Johannesburg for more than a year.

[87] Singh (2007) refers to a study carried out in Durban's central business district, a hub of informal trading activities, where women identified theft and criminal violence as obstacles to their work that were almost on a par with the lack of capital for business.

[88] Kiwanuka, 2008

and be sexually available to them. It is hard to know the prevalence of corrective rape because the prevalence of disclosing lesbian relationships in surveys is low, not least because of stigma associated with same sex relationships. A recent research study among 591 lesbian women living in Botswana, Namibia, South Africa and Zimbabwe showed that 31.1% of them had experienced forced sex by men or women. Having experienced forced sex was a predictor for HIV positivity.[89]

Sex workers

Sex workers are particularly at risk of physical and sexual violence from clients, pimps and the police. The greatest risk is among those who work outdoors. Rape of sex workers is very common and there are also commonly reports of them being left naked, abandoned in isolated places, beaten and robbed. Recent research has also highlighted that men who have sex with sex workers are much more likely to have been violent towards women and to have raped than other men, as well as having been involved in a range of other illegal activities such as theft and drug use.[90] This indicates that sex workers are vulnerable to violence because of the illegal and stigmatized nature of their work, the violent and illegal tendencies among their client group and their vulnerable position as women in South Africa.

Harmful cultural practices

UN Women defines "harmful cultural or traditional practices" as "the result of gender inequality and discriminatory social, cultural, and religious norms, as well as traditions, which relate to women's position in the family, community and society and to control over women's freedom, including their sexuality"; forms of violence include, inter alia, "female genital mutilation, female infanticide and prenatal sex selection, child marriage, forced marriage, dowry-related violence, acid attacks, so-called "honour" crimes, and maltreatment of widows". [91]

It is beyond the scope of this report to provide a detailed account of all harmful cultural practices therefore only a few of them are presented.

There is evidence that forced marriage is prevalent in certain communities, particularly in Eastern Cape and KwaZulu-Natal. *Ukuthwala* is aform of abduction that involves kidnapping a girl or a young woman by a man and his friends or peers with the intention of compelling the girl or young woman's family to endorse marriage negotiations. The *ukuthwala* custom was widely practiced in Nguni communities and was traditionally intended for people of the same age group who, in the normal course of events, would have been expected to marry each other. Today, *ukuthwala* increasingly involves the kidnapping, rape and forced marriage of minor girls as young as 12-years-old by grown men.[92] In other cases, the friends or peers of the abductor assist and participate in the rape and beating of the girl child.[93] Some researchers indicate that poverty fuels the practice, with poor families using the early marriage of daughters as a strategy for reducing their own economic vulnerability.[94] However, no rigorous research was found to assert this fact. In the MRC's 2008 study of men in the Eastern Cape and KwaZulu-Natal 7.3% of the 233 married men who were living in Eastern Cape's

[89] Sandfort et al, 2013
[90] Jewkes et al,2012
[91] UN Women, 2012
[92] Maluleke, 2009
[93] Commission for Gender Equality (CGE), 2012
[94] Modisaotsile, 2013

OR Tambo district had married by *ukuthwala* and a further 4.7% of men had a marriage that was negotiated by the woman's male elders that the she was then forced to agree to.

Murders associated with witchcraft accusations have also been reported in various South African provinces particularly the Eastern Cape and Limpopo, as revealed by a research not yet published.[95] Witchcraft was given as the reason by police for the murder of 28 women in South Africa in 2009. More than 60% of these women were 60 years and older, 75% lived in rural areas and all these witchcraft-related murders happened in the Eastern Cape and KwaZulu-Natal. A qualitative research study documented three cases in the Transkei (Eastern Cape) and highlights the issues related to witchcraft accusation in this area.[96] The author, a Forensic Pathologist, estimated that about 50 to 60 bodies of elderly women brought to Umtata General Hospital mortuary every year had been attacked after accusations of witchcraft. There are four characteristic features of witchcraft accusation related deaths. First, a witch accused is most often woman (often dark and short), secondly they are elderly (more than 50-years-old) thirdly, the perpetrator is often related to the victim or very well known to her, and fourthly, there is some sort of community consensus or permission to eliminate these witches. The literature review found no evidence on the magnitude of this phenomenon.

Finally, it is important to note that unpublished research from the MRC shows that female genital mutilation (FGM) is not a harmful cultural practice in South Africa. In northern parts of the country, labial lengthening is traditionally practiced but this does not fall under the definition of FGM as it does not involve cutting and women do it themselves.

1.2.6 Implications: risk factors and intervention priorities

Key facts

- South Africa has a substantial base of research on prevalence as well as risk factors of VAW and this is supported by research from other countries. This constitutes a solid base for the development of priorities and prevention interventions.
- The section above has highlighted the risk factors that have been demonstrated through research, the levels at which they operate and has sought to highlight connections and underlying factors and processes. Because of these interconnections, interventions are much more effective when they target multiple risk factors and operate at multiple levels. Detailed recommendations and examples of interventions are presented in the conclusion of this report.

1.3 Analysis of the impact of IPV and SV in South Africa

VAW has major social and developmental impacts for the women, their children and society in general, and constitutes a violation of human rights. At the same time, VAW is a risk factor for a variety of diseases and conditions as well as a source of injury and injury-related mortality. This section will mainly focus on the health impacts of VAW and presents a brief overview of the economic impacts.

[95] Abrahams et al, 2013
[96] Meel, 2009

In South Africa interpersonal violence is one of the top 10 causes of death and research has shown that gender inequity and violence is one of the most important risk factors for HIV, especially in young women, which is the leading cause of mortality nationally.[97] Many of the more important health risk behaviours are for chronic diseases, particularly smoking and alcohol abuse.

1.3.1 Injury

The most direct health effect of violence is injury, and at its most severe, homicide. In the Three Province Study [98]women were asked about injury following IPV and between one-third and two-thirds of women who had ever been abused had been injured and usually on more than one occasion. The severity of the injury is indicated by the high proportion seeking medical attention, which in two provinces was over 90% (**see table 5**). The table below also shows estimates for the cost of treating injuries and the social cost of spending days in bed away from normal social activities and taking days off work. The 95% confidence intervals are quite wide, but they demonstrate a substantial social and economic burden due to IPV-related injury.

Table 5: Findings of the MRC's Three Province study on injury due to IPV, health care seeking and its economic and social costs

Variable	Eastern Cape (95% CIs)	Mpumalanga (95% CIs)	Northern Province (95% CIs)
Total number of women aged 18-49 years	1 218 526	589 165	928 470
Proportion of women abused by a current or ex-partner who were injured	34.9	48.0	60.0
Mean no. of times injured	2.46	2.09	1.75
Proportion seeking medical attention	91.7	62.5	91.7
No. of episodes of health sector visits due to injury after partner abuse in one year	121 000 (69 943-171 934)	74 294 (29 929- 118 717)	93 868 (29 247 - 158 397)
Estimated cost of health sector visits for these injuries in one year (Rands, 1998 prices)	12 220 963 (7 064 283- 17 365 336)	7 503 694 (3 022 888- 11 990 391)	9 480 700 (2 953 927- 15 998 095)
Days lost from work in the province due to injury after partner abuse in one year	96 751 (0- 206 540)	178 929 (0- 429 855)	197 392 (12 349-382 530)
Days spent in bed in the province due to injury after partner abuse in one year	480 709 (165 841-795 697)	154 184 (79 950-228 419)	263 871 (91 826-435 917)

Source: Jewkes et al, 1999

1.3.2 HIV and STIs

Over the past decade, there has been growing recognition that IPV is an important contributor to women's vulnerability to HIV and sexually transmitted infections (STIs).

[97] Jewkes, 2010
[98] Jewkes, 2002

The most important findings have been the evidence that:

- Young women who are HIV-negative but have been exposed to IPV are 50% more likely than other women to develop HIV over a period of two years.
- Similar to the violence outcome, 11.9% of new HIV infections could be prevented if women did not experience more than one episode of physical or sexual partner violence.[99]

Young women who are HIV-negative but have been exposed to IPV are 50% more likely than other women to develop HIV over a period of two years.

11.9% of new HIV infections could be prevented if women did not experience more than one episode of physical or sexual partner violence.

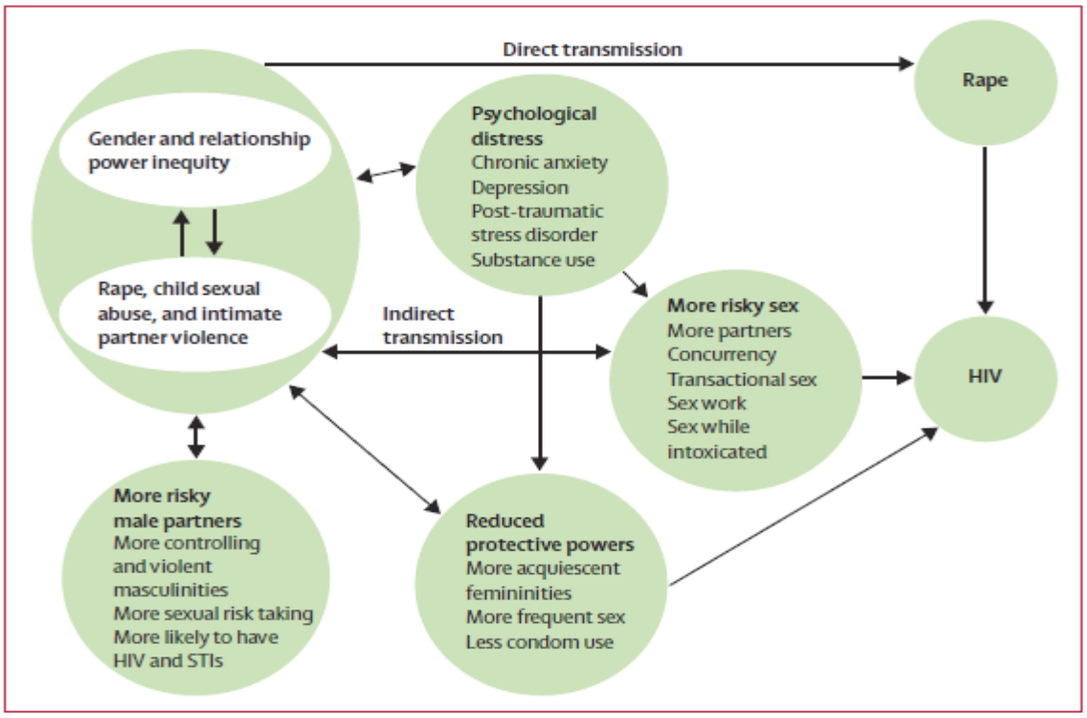

***Figure:* Pathways through which gender-based violence and gender and relationship power inequity might place women at risk of HIV infection**
STIs=sexually transmitted infections.

Figure 6: Pathways through which VAW and gender & relationship power inequity might place women at risk of HIV infection

Source: Jewkes, 2010

The mechanisms underpinning a woman's increased vulnerability to HIV or STIs include direct infection from forced sexual intercourse, as well as indirect transmission factors including: limited control over the timing or circumstances of sexual intercourse, or limited ability to negotiate condom use for women living in a

[99] Jewkes, 2010. These findings are based on a longitudinal analysis of data from a control trial undertaken in the Eastern Cape province of South Africa between 2002 and 2006. 1,099 women aged 15–26 years who were HIV-negative at baseline were enrolled in the research.

controlling relationship[100] (see Figure 6 above). Partner violence may also be an important determinant of separation, which in turn may increase a woman's risk of HIV if she acquires a new partner. Furthermore, there is evidence that men who use violence against their female partners are more likely than non-violent men to have a number of HIV-risk behaviours.[101] Finally, female partners disclosing their HIV-positive status can lead to IPV.[102]

1.3.3 Mental Health

The most highly prevalent consequences of VAW are mental health problems. There is considerable evidence that women who have experienced IPV and been raped are at higher risk of depression, anxiety disorders, PTSD, substance abuse, suicidal thoughts and attempts, eating disorders and obsessive compulsive disorders. Research among young women from the rural Eastern Cape shows that those without mental health problems who were exposed to physical or sexual IPV were significantly more likely to develop depression, alcohol abuse or suicidal thoughts over two years after the violent event.[103] Emotional abuse increased the risk of depression among all women, including those with physical or sexual IPV exposure. Research also shows that mental health impact is compounded by poly-victimisation, thus there is a cumulative effect of non-partner rape and emotional abuse as well as sexual or physical IPV. Domestic violence is associated with the greatest number of lifetime PTSD cases among women. Rape was found to be the most pathogenic form of violence with regard to PTSD.[104]

Domestic violence is associated with the greatest number of lifetime post-traumatic stress disorder (PTSD) cases among women. Rape was found to be the most pathogenic form of violence with regard to PTSD.

PTSD as a consequence of child sexual abuse has also been the subject of research. A 2013 study found that almost half of a sample of children studied after rape met clinical criteria for anxiety, and two-thirds met criteria for full symptom PTSD two to four weeks post-rape disclosure. When assessed nearly six months later, 43.3% of children still met full symptom PTSD.[105] All mental health problems are treatable but they require services to be provided and current mental health services are very ill equipped to provide care for victims of trauma.

1.3.4 Unwanted pregnancy, miscarriage, abortion and teenage pregnancy

Prevalence of violence during pregnancy is very high in Africa[106] and is a recognised cause of miscarriage, still birth and maternal mortality in South Africa. Other negative maternal and child health outcomes associated with violence against pregnant women include preterm labour, pregnancy complications, hypertension, delivering low birth weight babies, and post-partum depression.

[100] Tsai et al, 2012, secondary analysis of cross–sectional data pooled from 22 Demographic and Health Surveys conducted in sub-Saharan Africa, data from 198,806 sexually active women living in 22 sub-Saharan African countries were analysed.
[101] WHO, 2013
[102] WHO, 2004
[103] Jewkes, 2013
[104] Kaminer et al, 2008, as quoted by Tshwaranang Legal advocacy Centre 2010; sample: nationally-representative data from 4351 adults.
[105] Matthews et al, 2013
[106] Shamu et al, 2011

Teenage pregnancy is associated with forced first sexual intercourse. In a study among young pregnant women, those whose first sexual encounter was forced were 14 times more likely to have a teenage pregnancy.[107] Research among adolescents in the Eastern Cape shows that experience of IPV increases the risk of teenage pregnancy by 70% over two years.[108] International research has shown that abortion is much more common among women who have experienced VAW.[109] It is essential that pregnant teenagers are asked about abuse exposure and that appropriate police reports or counselling are made or offered.

In a study among young pregnant women, those whose first sexual encounter was forced were 14 times more likely to have a teenage pregnancy.

1.3.5 Economic impacts of VAW

According to the World Bank, conservative estimates of the economic costs of loss of productivity due to VAW are around 2% of global GDP globally.[110]

The short-term costs associated with VAW may include loss of earnings for time-off work, moving expenses, school transfers, trips to the police station, accessing court services, childcare costs, doctors' appointments, and psychological support. Long-term costs may involve legal fees, medical and psychological treatment, disability leave from work, on-going court dates and follow-up visits to the police station. The mental health cost of VAW has not been researched.

At each stage of VAW, the State incurs expenses in its justice and legal systems, medical and social systems, refuge and support systems, educational institutions and public assistance offices. At each stage, private businesses, social welfare organisations, shelters, school systems, medical facilities and communities, also incur extensive expenses and financial losses as a result of dealing with the consequences of violence. Consequently, the cumulative economic impact of domestic violence on the government, public sector, private sector and society as a whole is enormous and has substantially interfered with South Africa's economic growth and stability.[111]

1.3.6 Implications: the health response to VAW

This section has highlighted that not enough is known about the economic and social development impacts of VAW in South Africa and that more detailed costing exercises must be conducted. There is however more substantial research on the health impacts of VAW. Research has found that VAW accounts for a substantial disease burden and has an important impact on health services and the economy.[112] Preventing VAW and therefore reducing this burden is of highest importance. It is also critical that health services are made aware of this burden and are appropriately responsive. This is only possible if there is investment in staff training, if

[107] Jewkes et al., 2001; research based on a control study ofyoung (<19 years) teenagers in Cape Town (544 adolescents, 191 of whom were pregnant). 32% of those who were pregnant and 18% of those who were not reported that their first sexual intercourse was forced
[108] Jewkes, 2010
[109] Devries et al, 2013
[110] http://www.worldbank.org/en/events/2013/10/11/Tackling-Gender-Based-Violence-After-2015
[111] Adapted from Stone and Watson, 2013
[112] Norman et al, 2007

appropriate services are available and if service management takes into account the resource needs for such care when planning services.

In 2013, the World Health Organisation published guidelines for an appropriate health sector response to VAW based on a comprehensive review of the scientific evidence. There were three central elements to the conclusions of the review.

(1) That the health sector has an important role to play in post-rape care and that these services must be provided by trained health professionals

(2) That routine case identification (or screening) in health services for VAW exposure is not recommended, but that health professionals must ask about VAW exposure in services where it is essential to have this information for optimal health care provision. These services include, but are not limited to, all mental health services for women, counselling for women testing HIV-positive and services providing treatment for women who have been injured.

(3) That mental health services for victims of trauma must be provided, including psychological first aid for those presenting acutely and treatment for depression and PTSD where indicated.

Chapter II: Know your response

The South African response to VAW is supported by a comprehensive legal framework and various government and civil programmes that aim to prevent and respond to the epidemic. However, in 2011 the Commission for the Elimination of all forms of Discrimination against Women (CEDAW) Committee noted that it was "concerned about the inadequate implementation of effective and comprehensive measures to modify or eliminate stereotypes and negative traditional values and practices in South Africa" and recommended that government puts in place "mechanisms of accountability to ensure the implementation of the provisions contained within policies and legislation, such as the Domestic Violence Act and the Sexual Offences Act, to combat violence against women"[113]. Since then, the DWCPD was set up, violence has been declared a priority in the National Development Plan and an Inter-ministerial Task Team on roots causes on violence against women and children was created, while many NGOs and government programmes remained active in preventing and responding to VAW.

This section reviews achievements and challenges related to the legal framework, the government and civil society response, based on a review of the literature and key informant interviews (**see list of respondents in Annexure 1**). It also presents a synthetic review of South African SBCC programmes relating to VAW.

2.1 Overview of the national VAW measurement system and statistics collected

2.1.1 South African's international VAW reporting obligations

International conventions

South Africa is a signatory to the United Nations (UN) Convention on the Elimination of all forms of Violence against Women. As a signatory, South Africa is requested to submit reports to the UN Secretary-General on

[113] Ertürk, 2008

the legislative, judicial, administrative or other measures it has adopted to implement the Convention at least every four years. South Africa submitted reports in 1998 and 2011.

Launched in 2009, the Secretary-General's Database on Violence against Women was established through the UN General Assembly Resolution 61/43. It is the first 'one-stop site' to capture measures undertaken by Member States on all forms of VAW. To date South Africa has reported on its legal framework, as well as some VAW policies, strategies and programmes and institutional mechanisms. It has not yet reported on VAW services and preventatives measures, nor on research and statistical data.[114]

South Africa also reports to the United Nations Economic Commission for Africa (UNECA). The 2013 UNECA African Women's Report (AWR) [115] was dedicated to the issue of the socioeconomic cost of violence against women and girls in Africa. The DWCPD compiled a report on this issue, outlining some of the available statistics and programmes on VAW in South Africa.

Data required

Since 2008, the UN has been working on harmonizing data collected on VAW and designing a set of indicators to measure prevalence.[116] These indicators measure different forms of violence in the last 12 months and during lifetime:

- Total and age-specific rate of women subject to **physical violence** by severity of violence, relationship to perpetrator(s) and frequency;
- Total and age-specific rate of women subject to **sexual violence** in the last 12 months by severity of violence, relationship to perpetrator(s) and frequency;
- Total and age-specific rate of women subject to **physical or sexual violence by current or former intimate partner** by severity of violence and frequency;
- Total and age-specific rate of women subjected to **psychological violence by the intimate partner** (added December 2009);
- Total and age-specific rate of women subjected to **economic violence by the intimate partner** (added December 2009);
- Total and age-specific rate of women subjected to **female genital mutilation** (added December 2009);

Incidence and prevalence of the different forms of violence presented above are currently not routinely measured in South Africa.

2.1.2 South Africa's VAW surveillance system

South Africa currently does not have a national VAW public surveillance system that would centrally gather, analyse and disseminate all service delivery data collected by government departments. Such a system could inform prevention and programme responses, evaluate the cost of VAW, monitor the quality, scope of and demand for the services, and ultimately ensure accountability. The system could be coordinated

[114] http://sgdatabase.unwomen.org/countryInd.action?countryId=1207
[115] DWCPD, 2013
[116] In 2011, a set of nine core indicators were presented to the 42nd session of the Statistical Commission in 2011.

by a lead department, it could be less formal and managed as "a partnership between sectors and agencies working collaboratively to deliver IPV and SV prevention programmes in a coordinated way",[117] or it could even be located in a 'VAW observatory' made up of CSOs and government departments.

At present various service-level administrative data is collected by various departments who then develop indicators and statistics. Some departments are seeking to centralize this data as it is required by their legislative mandate or the programmes they implement. For example, DoJ is centralizing data to report against the Sexual Offences Act (SOA) while DSD is reporting on the Victim Empowerment Programme (VEP). Data currently collected by SAPS, DoH and DoJ is presented in the section below.

2.1.3 South African Police Service Crime Statistics

The SAPS crime statistics reports contain data that is routinely collected at various police stations across the country. The data is collated and reported via a comparative longitudinal approach which aims to describe crime trends in South Africa. The descriptive analysis is reported using crime categories of which common assault and sexual offences are classified under 'contact crime'.

Between 2004 and 2012, 535,768 sexual offences were reported to SAPS.[118] This includes rape, sexual assault and other crimes. As seen in Table 3, the number of reported adult female victims of all sexual offences remains high – over 60,000 in the period 2007/2008 to 2011/2012. Under sexual offences, sexual assaults and rape are recorded, together with other sexual offences such as 'bestiality' or 'procuring females for prostitution'. The subcategory 'rape' includes "acts of consensual sexual penetration with certain children (12 years and older but under 16 years) – formerly defined as statutory rape".[119]

The number of reported adult female victims of all sexual offences remains high – over 60,000 in the period 2007/2008 to 2011/2012.

In the period 2011/2012, 48.5% of all reported sexual offences were of adult women, with 40.1% of these being among children. There has been a downward trend in the total number of sexual offence cases reported, which is part of an overall reduction in the crime ratio from 133.4 per 100,000 in 2007/2008 to 127 per 100, 000 in 2012/2013. However, the sexual assault crime ratio increased by 0.7% from 2008/2009 to 2012/2013.

Table 6: South African Police Service Sexual Offences Statistics Indicators 200 -2013

Indicator	2007/ 2008	2008/ 2009	2009/ 2010	2010/ 2011	2011/ 2012	2012/ 2013	Denominator
Reported cases	63 818	70 514	68 332	66 196	64 514	66 387	Absolute numbers
Crime Ratio per 100 000 of the population	133.4	144.8	138.5	132.4	127.5	127.0	Total population
Percentage of total sexual offences reported against women 18 years and older	49%	72.7%	52.8	54%	48.5%		Absolute numbers

Source: SAP[120][121]

[117] WHO, 2010
[118] SAPS as quoted by Thorpe, 2013
[119] SAPS, 2012
[120] Crime Research and Statistics - South African Police Service, 2012. http://www.saps.gov.za/statistics/reports/crimestats/2012/categories/total_sexual_offences.pdf
[121] Crime Statistics Overview RSA, 2012 http://www.saps.gov.za/statistics/reports/crimestats/2012/downloads/crime_statistics_presentation.pdf

Additional analysis undertaken by SAPS indicates that reported sexual offences have reduced by 10.9% over nine years (2004/5 - 2012/13); by 12.3% during the past four years (2009/10 - 2012/13) and 0.4% during the past financial year (2012/13).[122] However, over the same 10-year period, sexual offences increased by 40.9% in Limpopo, 15.1% in North West province, 19.8% in Free State and 21.8% in the Eastern Cape. In addition, when adding up all the reported contact crimes against women between 2007 and 2012 this totals 953,939 contact crimes against women. Other data communicated by SAPS to the MRC shows a total of 48,325 rapes reported nationally in 2013.

SAPS is required to maintain a register of IPV cases reported to police stations and consolidate this data monthly, however these reports are not available. The only data found on domestic violence was reported to the Portfolio Committee and Select Committee on Women, Youth, Children and People with Disabilities. This data is outdated and shows a total of 35,495 cases reported in 2010.[123]

Box 1: Critical review of SAPS statistics

Only crimes reported to the police are included in SAPS statistics. As such, these statistics are an indication of women's access to the criminal justice system rather than the prevalence of rape and domestic violence.

It is impossible to distinguish a decrease in reporting rates from a decrease in the actual incidence of a particular crime. However, as under-reporting is very high in South Africa (latest available research shows that one in 13 women raped by a non-partner had ever reported rape to the police)[124] an effective criminal justice system response to sexual offences would initially translate into increased rates of reporting, as more women would be keen to report. The downward trend of reported sexual offences observed here is worrying as it could suggest that fewer women report and there are low levels of confidence in the criminal justice system.

The category 'sexual offences' includes a lot of different crimes, which makes it difficult to single out rape statistics. In addition, the subcategory defined as 'rape' includes consensual sex with children between 12 and 16 and data is not readily available making it difficult to monitor reported acts of rape that are non-consensual.

SAPS does not have a specific crime category on domestic violence. Instead, cases are captured under 'common assault' together with other crimes, making it impossible to measure trends in reporting IPV. Although the Domestic Violence register should inform the number of reported cases, to date no report has been made available using this data. Furthermore the IPV category is not useful for monitoring VAW as it is not restricted to an act of violence by a male partner against a woman.

2.1.4 South African Department of Justice (DoJ)

The DoJ gathers statistics related to protection orders, criminal prosecutions for domestic violence and sexual violence. The NPA on the other hand maintains data on the number of cases reported to the Thuthuzela Centres (TTCs).

As these statistics inform the response of the criminal justice system, they are presented in the section related to the DoJ and NPA responses.

[122] SAPS, 2013, An Analysis of crime statistics 2012-2013
[123] Thorpe, 2013
[124] Gender Links and the Medical Research Council, 2010

2.1.5 Department of Correctional Services

The only data that could be found from the Department of Correctional Services is from 2009 and indicates that 18,420 men were incarcerated for sexual crimes (including 15,793 rape perpetrators). However, the number of men convicted for sexual offences between 2007 and 2012 ranges between 2,887 and 4,501 per year. The discrepancy between the number of men convicted each year and the total number of men in prison for sexual offences need further investigation.

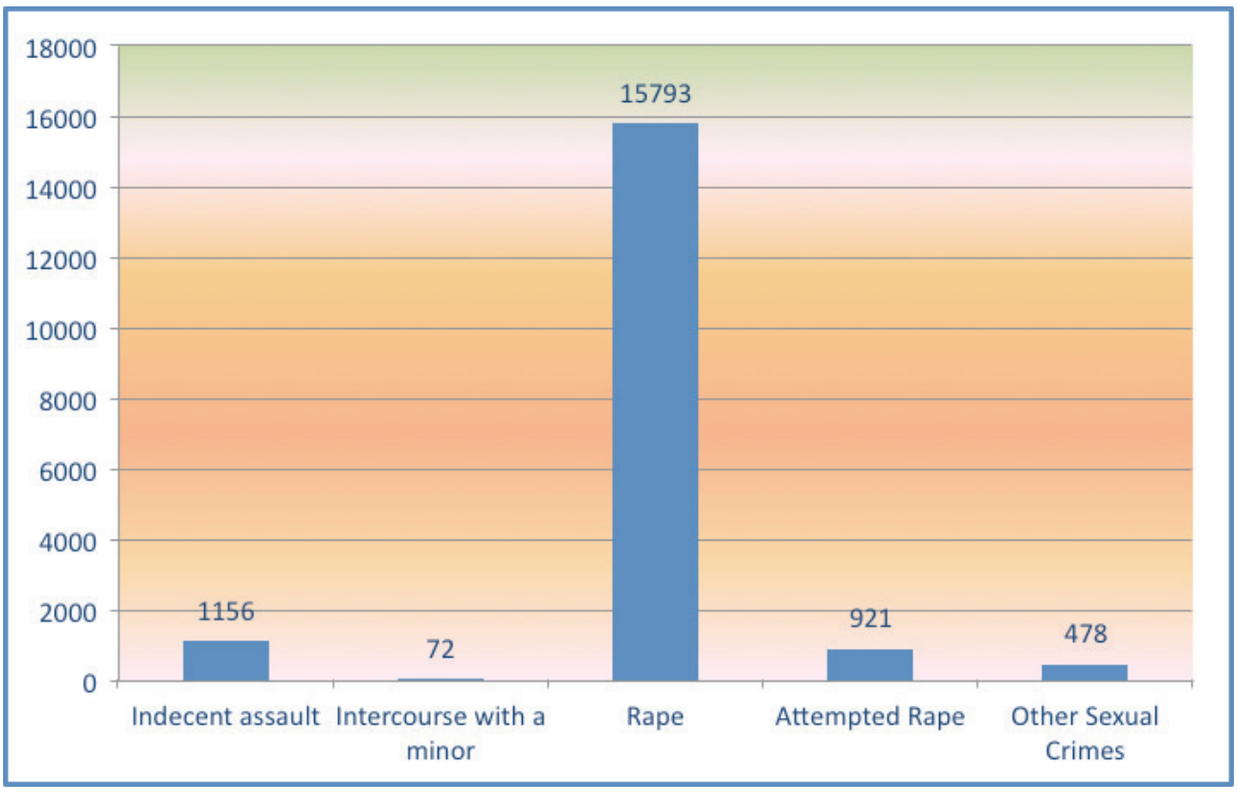

Figure 8 Sentenced offender statistics: Sexual Crimes as on 30 June 2009

Source: Department of Correctional Services. 2009. National Offender Population Profile.

2.1.6 VAW data derived from non-VAW specific national surveys

Demographic Health Surveys

The Demographic Health Survey (DHS) is an internationally recognise national population-based survey that provides national statistics on health. From 2011, DHS conducted in several Southern African[125] countries included questions on VAW, and methods of data collection were also improved. The percentages revealed by these surveys are comparable with the percentages revealed by studies looking exclusively at VAW, thereby confirming that DHS

[125] They include: Democratic Republic of Congo (DHS 20 11/12), Malawi (DHS 2010), Mozambique (DHS 2012), United Republic of Tanzania (DHS 2010), Zambia (DHS 2007), Zimbabwe (DHS 2010/11).

can now be used as reliable source to measure VAW, which was not the case in the past.[126] The 1998 South African DHS included questions on VAW that did not work very well and a validation study showed that there was very substantial under-reporting. Consequently, the 2003 DHS did not include these questions. The country is now preparing for a DHS in 2014 or 2015 and it is hoped that this will again include VAW questions.

Victims of Crime Survey

The Victims of Crime Survey (VOCS) is a South African countrywide household-based survey which measures people's perceptions and experiences of crime.[127] To date, five surveys have been conducted – in 1998, 2003, 2007, 2011 and 2012. The VOCS also contains statistics on who the perpetrators are and where the sexual offence took place. The number of sexual offences reported in the VOCS 2012 (32,000) is half the number of cases reported to the police the same year.

Box 2: Critical review of VOCS

The sexual offences were largely under reported in these surveys and should not be used as an accurate source of sexual assault prevalence. This is due to the fact that levels of disclosure are usually lower in questionnaires not specifically tackling VAW, and when interviewers have not trained for administrating questions relating to VAW. In addition, the survey questions only explore sexual offences (including rape) in the past year, and do not look at sexual offences ever experienced in one's lifetime (as per recommended indicators).

2.2 South Africa's legal and policy frameworks

The Domestic Violence Act (116 of 1998) and Amendment No. 32 of 2007 (DVA)

The DVA has an open-ended definition of domestic violence. It places positive duties on the police to assist victims of domestic violence and provides for women and children under 18 to apply for a protection order, recognises same-sex relationships and includes an extensive list of abuses which include but are not limited to: physical abuse; sexual abuse; emotional, verbal and psychological abuse; and economic abuse.[128]

Among the challenges hampering the Act's implementation is the fact that it was not costed and is under-budgeted, there is a high rate of attrition of protection orders and not all officials are familiar with its content. The DVA does not place any legal obligation on DSD to provide shelter and counselling or on DoH to provide medical treatment.

[126] The surveys conducted in the last three years revealed that between 28% and 64% of women aged 15-49 years reported ever experiencing violence (in Malawi and Democratic Republic of Congo respectively); and between 14% and 49% of women reported experiencing violence last year in the same countries.

[127] Victims of crime survey, 2012

[128] The other types of abuse include are: intimidation; harassment; stalking (repeatedly following, pursuing, or accosting a complainant); damage to property; entry into the complainant's residence without consent, where the parties do not share the same residence; or any other controlling or abusive behaviour towards a complainant, where such conduct harms, or may cause imminent harm to, the safety, health, or well-being of the complainant (Domestic Violence Act, No. 116 of 1998).

Criminal Law: Sexual Offences and Related Matters Amendment Act 2007 (Act No. 32 of 207) (SOA)

The SOA has extended the definition of rape, created new crimes and classifies forced sex in marriage as rape. It also specifies minimum sentences for certain categories of crime, under offenders. The Act places legal obligation on the DoJ, NPA, SAPS, DoH, DSD, and Correctional Services, which includes participation in an inter-sectoral committee (ISC), and requires NPA, SAPS and DoH to develop training courses. One of the implementation challenges is that many officials are not familiar with the content of the SOA.

The Service Charter for Victims of Crime in South Africa (The Victims Charter 2007)

This charter specifies minimum standards of service that must be provided to victims of crime across the criminal justice system. It includes the police, courts, social services and Correctional Services.

Other legal frameworks and acts contribute to prevent violence in South Africa. An example is:

The Firearms Arms Control Act of 2000

Although the overall aim of this Firearm Control Act (FCA)[129] was to prevent armed violence in general, the national study on femicide has shown the correlation between the introduction of the Act and reduction in female homicides. The research show that the Act has made a contribution in reducing gun related homicides with a significant decrease in gun-related femicides with 529 fewer women killed by guns in 2009 compared to 1999[130.] The FCA has a range of provisions, including disqualifying applicants for a gun licence and declaring a person 'unfit to possess a firearm' in the event of a Domestic Violence charge or conviction. The impact of this Act on violence against women has occurred despite critiques of the inadequate implementation of the Act. Strengthening it is therefore critical as part of the response to VAW.

Legislation enhances the response to violence not only by protecting and guaranteeing rights for victims, but also by compelling government to secure budget allocations. It also "specifies the responsibilities of various state bodies in implementing legislation, which facilitates clear accountability chains".[131]

2.3 Department of Social Development (DSD)

Mandate

The mandate of DSD in tackling VAW is to prevent violence against women and children; to respond to violence in an integrated and coordinated manner; to monitor prevalence and incidence of gender-based violence against women and children; and to ensure follow-up and support the reintegration of victims of VAW.[132]

[129] Republic of South Africa. (2004) Firearms Control Act no 2000, http://www.info.gov.za/view/DownloadFileAction?id=682298;
[130] Abrahams N, Mathews S, Martin LJ, Lombard C, Jewkes R. 2013. Intimate partner femicide in South Africa in 1999 and 2009. PLoS Med. 10(4).
[131] Dey, K, et al, 2011
[132] DSD, April 2013

The DVA does not place any legal obligation on DSD but places an obligation on SAPS to refer the complainant to a shelter or medical services. However, policy and programmes guidelines have been put in place by DSD and the most recent ones include:

- *Policy Framework and Strategy for Shelters for Victims of Domestic Violence in South Africa* (2003):
- *Strategy for the Engagement of Men and Boys in Prevention of Gender based Violence* (2009);
- *Integrated Social Crime Prevention Strategy* (2011) – covers most of the primary prevention areas;
- *The National Policy Guidelines for Victim Empowerment* (2009) – aims at integrating and coordinating services;
- *Social Development Guidelines on Services for Victims of Domestic Violence* (2010);
- *Guidelines for Services to Victims of Sexual Offences* (2010).

Programmes' content and achievements

The Victim Empowerment Programme (1999)

Coordinated by DSD within the Justice Crime Prevention Strategy (JCPS) Cluster, the VEP is one of the key outputs of the National Crime Prevention Strategy developed in 1998. Constituted by the core National Crime Prevention Departments and provincial departments as well as DSD, it aims to guide the development of plans for the implementation of policies and legislation, including DVA and SOA, and the development of governance systems. Some of its objectives are to develop a policy package to guide "integrated and inter-sectoral programmes and services in the victim empowerment sector"[133], to enhance service delivery, particularly in rural areas, and training, including for CSOs.

VEP services range from shelter provision to preparing survivors for court hearings. DSD is responsible for:

- **Managing shelters** which provide accommodation to survivors for up to six months. DSD reports having 96 shelters, most of them managed by NGOs.
- **Awareness and education:** Including the Everyday Hero Programme, community dialogue, door to door campaigns and social mobilization.
- **Therapeutic interventions:** Providing psychosocial services.
- **Life skills programmes:** Parental skills, family strengthening and support programmes.
- **Funding:** DSD has put in place mechanisms to assist and reassess the VEP funding criteria for CSOs.[134] It has developed costing models for all VEP services, including shelters and to ensure uniform funding.
- **A One Stop Centre and Victim Support Model** (Khuseleka Centres) has been developed, with shelters attached. Seven have been open so far.
- DSD partnered with NPA in providing **sexual offences training** for Thuthuzela Care Centres.
- **The green door programme:** The doors of some houses with a community are painted an identifiable colour so that IPV survivors can easily identify them and seek refuge;
- **A National Directory on Services for Victims of Domestic Violence and Crime** was published in 2009. It lists VEP services by province and town, with contact details. The categories of services are 'court

[133] DSD
[134] DSD Annual Report, 2012

preparation and support', 'generic social services' and 'special services for victims'. It also publishes services provided in shelters.

DSD is coordinating an Inter-Ministerial Committee on the root causes of violence against women and children. Initially aimed at producing research on the root causes, the committee has now developed a Violence against Women and Children's Programme to provide an overarching plan for the implementation of violence prevention measures.

DSD is also one of the main departments contributing to the prevention of VAW by tackling the contributing risk factors, such as adverse childhood experiences and alcohol abuse or delinquency, and through Prevention and Early Intervention Programmes (PEIP).

- **The Draft White Paper on Families in South Africa** seeks to address the issue of the "disintegration and vulnerability of families". It is costed and an implementation plan will be developed and a national Inter-departmental structure for services to families will be set up under the lead of DSD, with the Office of the Presidency as an equal partner.
- **Peer pressure and delinquency:** A number of social crime prevention and therapeutic programmes have been developed. In 2012, 220 master trainers were trained to implement therapeutic programmes aimed at providing structured services to children in conflict with the law.[135]

Initiatives not operationalised yet

- **The Victim Empowerment Case Management System** aims to improve referrals by collecting electronic data from different departments. These departments include DSD, SAPS, DoH, DoJ and Correctional Services. The system will allow tracking of cases until conviction and should be launched soon.[136]
- **A toll-free line for victims of violence** has been developed and is due to launch soon (date unspecified).
- The **Prevention of and Treatment for Substance Abuse Act, No. 70 of 2008** should be operationalized during the 2013/14 financial year. It lays the basis for provinces and departments to develop plans to combat substance abuse. The Act discusses the development of Local Drug Action Committees bringing together communities and local government. The committees would increase awareness of substance abuse, directly protect women in danger and hold government services accountable for tackling substance abuse.
- **The DSD Gender-Based Violence Prevention Programme** (draft from 2012) is aimed at "providing operational guidance to government departments, advocacy and lobbing organisations and community-based service providers in the financial and operational planning of preventative programmes and actions"[137]. It has developed 10 strategies as well as defining activities, target groups, role players and outcomes. However this multi-sectoral programme lacks an overall action plan with timelines and budget – it is also not clear who is assuming the overall coordination role and what the accountability mechanisms are.

[135] DSD Annual Report, 2012
[136] Information from interview respondent
[137] DSD, 2012b

Challenges

- The DVA does not place a legal mandate on DSD to provide shelter and counselling, therefore service delivery is guided by policies that lack binding power upon officials and weakens the referrals between the police station and the shelter.

Shelters

- **Inequitable service provision:** There is a severe shortage of shelters for women, particularly in rural areas, as reported in public hearings,[138] with only three in Mpumalanga and in North West provinces.
- **Funding:** DSD directly runs three shelters and funds CSOs to manage the rest. All stakeholders agree that the funding is not nearly enough.
    - The State currently only provides a small percentage (in most instances less than a third) of the cost per head per day of each woman and her children at a shelter.[139] For example, DSD's budget allocation for shelters in the Western Cape covered only 12.7% of the people who may have needed shelter, most of whom were women and children. When determining the budgetary allocation for shelters for the 2011-2012 fiscal year, DSD aimed to provide 3,091 people with access to VEP-funded shelters (nearly half the number of women who attempted to access shelters that year). Although a number of shelters have managed to survive in spite of severe economic difficulty, hundreds of women and children are still turned away due to limited funding and an insufficient number of shelters.[140]
    - NGOs report that funding is inconsistent and varies across provinces, partly because the budget allocated to provincial departments by DSD is not ring-fenced. DSD decreased the budget allocated to NGOs in 2012, putting some of them in a dire financial situation that was at times compensated by once-off emergency funding. Finally, another inadequacy of DSD financing model relates to an underestimation of the cost per service beneficiary.[141]
    - The Women's Legal Centre (WLCE) and the Commission for Gender Equality (CGE) developed a recent policy brief "to advance the concerns of shelters housing abused women and children to the DWCPD by demonstrating the critical role they play in combatting domestic violence and by explaining the State's failure to adequately fund them".[142]
- **Minimum standards for shelters**: DSD's minimum standards for shelters have not been consistently met, partly because of lack of funding and lack of training.
- **Referrals:** The 2011 Victims of crime survey[143] points to deficiencies in the referral systems between police and psychosocial support provided by NGOs or DSD. This was confirmed during key informant interviews.

Coordination

- **Lack of interdepartmental collaboration** between all stakeholders responsible for victim empowerment.[144]
- **Provincial Level Forums:** Challenges include inconsistent membership and reporting; duplication of small committees in provinces, even if DSD encourages provinces to consolidate IPV, SV, trafficking in

[138] Sipamla, 2012
[139] Stone et al, 2013
[140] Ibid.
[141] Round-table on Gender-based violence, 22 April 2013.
[142] Stone et al, 2013
[143] Sat SA and ISS, 2011
[144] Sipamla, 2012

one committee;[145] and lack of political backing.[146]

- Not all respondents were aware of the DSD initiative to develop a **Victim Empowerment Case Management System** and indicated that there would be challenges in integrating their own system with an overarching one.

Duplication and lack of evidence-base in the programmes and laws

- Three respondents posited that the **Khuseleka One Stop Centres** were an unnecessary duplication of the TTCs managed by the NPA, and that the lessons learnt when establishing the TTCs were not taken into consideration when putting in place these new centres.
- There is no evidence proving the effectiveness and suitability of the Green Door Programme; nor is there a clear comparative advantage of a DSD-managed hotline – taking into consideration that hotlines have been managed by CSOs to date.
- Interview respondents pointed to the narrow scope of economic empowerment opportunities offered to women in shelters. These income generating activities tend to relate to women's traditional roles only (such as beading, sowing or cooking) and their effectiveness is not proven.
- Although strengthening families to avoid adverse childhood experiences can help prevent VAW, the 2012 White Paper on Families there is no clear theory of change on how it could bring meaningful solutions or enable social change. For example, the paper was criticized by the South African Institute of Race Relations for lacking practical proposals on how to address family breakdown, and for not sufficiently dealing with the role of attitudes, norms and individual behaviour, particularly patriarchal attitudes, which often still underlie family relations. The paper was also not seen as doing enough to empower women, particularly the most vulnerable from poorer and less-educated backgrounds.[147] The White Paper is also not informed by evidence of what works in prevention of child abuse and neglect, according to some interview respondents.
- **The IMC's processes and outputs** were questioned by several interview respondents as it has extended its initial mandate of producing research to develop an overarching programme of action, without consulting CSOs.

Future plans to respond to the challenges

To address funding challenges, DSD is currently exploring ways to use funding more effectively, by asking the Women's Shelter Movement to manage the funds and by lobbying Treasury to increase the envelope and put in place more training. In addition, the National Treasury's Medium Term Budget Policy Statement 2012 promised a significant amount of funding to relieve cash-strapped NGOs.[148] DSD is also working on a system to ring-fence the funds provided to provinces, using the National Development Agency.

To improve referrals, DSD has drafted a document proposing to locate social workers at community level, in clinics, schools and police stations and is in discussions with the relevant departments. DSD is also seeking to better respond to the needs of children living in shelters by developing new family units in the shelters that

[145] Interview respondent.
[146] Round-table on Gender-based violence, 22 April 2013.
[147] Submission by the South African Institute of Race Relations on the draft white paper on families released by DSDin July 2012.
[148] National Treasury, Republic of South Africa, Medium Term Budget Policy Statement 2012, 25 October 2012.

are being renovated.[149]

Finally, DSD is exploring the reintroduction of the Social Context Training of the Justice College, to sensitize government personnel working with VAW survivors – the training would be made compulsory. DSD is also exploring setting up Community Justice Forums, following the model of the Policing Community Forums, where the community would hold local stakeholders accountable for addressing VAW.

2.4 Department of Justice and Constitutional Development

Mandate

The DoJ is tasked with the protection of the rights of the vulnerable groups and to develop initiatives for the implementation and monitoring of the DVA and SOA, at departmental and inter-departmental level.

To achieve this mandate, several governance structures and programmes are in place:

- The **Director General Inter-sectoral Committee (DG ISC) monitoring the implementation of the SOA:** The committee comprises DGs or Heads of Departments from DSD, SAPS, Correctional Services, NPA, DoH, SAPS, and DoE, and was expanded to include DWCPD in 2011. The DG ISC meets at least twice a year to discuss implementation achievements and challenges, and each department is expected to develop an annual report on DVA implementation that is consolidated in one report. Only one consolidated report was produced for the period 2008-2011; the draft report 2012-2013 has been compiled but not yet published.
- **Provincial ISC forums reporting on the management of the SOA**
- **National Operational Inter-sectoral Committee** provides technical support to the DG ISC
- **Intra-departmental forum for the management of the SOA** ensures information provided by DoJ is inclusive.

Main achievements

- **The National Policy Framework on the Management of Sexual Offences (NPF)** was gazetted in September 2013. It will guide the implementation and enforcement of the Act in a coordinated way and includes a five-year strategic plan for the implementation of the national policy framework.
- **Re-establishment of the Sexual Offences Courts:** the plan is to develop 22 courts, with nine set up so far as pilot models. Originally used in South Africa between 2002 and 2005 (with 74 courts in 2005) these courts have proven they increase conviction rates by decreasing secondary victimisation; they also decreased the time between reporting a case to the police and finalizing the case.
- **Training:**
    - Working with DSD, developed an **Interdepartmental Training Manual on Sexual Offences, Victim's Charter and VEP for frontline staff,** and 450 frontline staff were trained in 2012;[150]
    - Additional training was conducted, including on the NSRO (National Sex Offender Registry), on the

[149] DSD presentation at the Round-table on Gender-based violence, 22 April 2013.
[150] DoJ, March 2013, Draft Annual report on the implementation of the SOA

HIV Act and inter-sectoral training of 450 front-liners (from DBE, DoH, DoJ):[151]

- Development of SAQA Unit Standards in the Justice College.

- **Protection orders issued.** There was a 4% increase in the number of protection orders made final from 2010 to 2011, but still a significant discrepancy between the interim protection orders and the final ones – with just over one-third of interim orders becoming final (see table 7). Notwithstanding cases where this was due to the applicant (for example who reconciled with the perpetrator or disappeared), evidence from Parliament public hearings shows that some complainants withdraw their demand because of secondary victimisation in the criminal justice system.[152]

Table 7: Number of Protection Orders granted from 2009-2011

Year	New Interim PO Application	PO Final	Warrants of Arrest for Breach
2009	226 402 (average of 18 886 per month)	79 098 (average of 6591 per month)	15 359
2010	224 486 (average of 18 707 per month)	80 714 (average of 6726 per month)	19 426
2011	217 987 (average of 18 165 per month)	87 711 (average of 7309 per month)	31 397
Total	668 875	247 523	66 182

Source: *Thorpe, 2013. Statistics and figures relating to Violence against Women in South Africa*

- **Prosecution for Domestic violence** As can be seen from table 8 below, the number of domestic violence criminal prosecutions has more than tripled between 2009 and 2010 (from 3,954 to 14,761) and came down slightly in 2011 (to 13,748). Yet on average more than half of the cases are withdrawn and the protection order finalization rate remains low.

Table 8: Criminal prosecutions 2009-2011

Year	New Matters	Finalised Matters	Withdrawn	Finalisation rate (%)	Withdrawal rate (%)
2009	3 954	1 071	1 892	27.1	47.9
2010	14 761	4 158	8 402	28.2	56.9
2011	13 748	3 726	7 531	27.1	54.8
TOTAL	**32 463**	**8 955**	**17 825**	**27.6**	**54.9**

Source: Thorpe. 2013. Statistics and figures relating to Violence Against Women in South Africa.

- **Prosecution for sexual violence.** The table below shows that the number of prosecutions has increased by 63% between 2007/2008 and 2011/2012, while the conviction rate remains the same. Additional comments are presented under challenges below.

[151] Ibid.
[152] Watson, 2012

Table 9: Prosecutions for sexual violence

	2007/2008	2008/2009	2009/2010	2010/2011	2011/2012
Sexual Offences reported to SAPS	63 818	70 514	68 332	66 196	64 514
Criminal Prosecutions for sexual offenders	4 365		-	-	6 913
Convictions	2 887	3 535	-	-	4 501
Conviction Rate	66.15%	66.7%	67.7%	-	65.1%
Number of offenders imprisoned for sexual offences and sentenced	17 775		18 405	18 128	18 040

Source: *Thorpe, 2013. Statistics and figures relating to Violence Against Women in South Africa.*

Initiatives not operationalised yet

- **Draft Amendment Bill of the SOA Act on Sexual Offences Court;**
- **Draft National Prevention Strategy on Domestic Violence** that will be accompanied by a detailed costed plan, once finalised.
- **Merging the NSRO with the Child Protection Register (CPR);** the registers provide details on age of victims and disability status and record historical convictions.

Challenges

- **Attrition of protection order cases:** Less than half of those who apply for protection orders ultimately qualify.[153] Reasons include loss of interest from the complainant, complainant untraceable, as well as "negative experiences of the criminal justice systems [that] triggers a form of secondary victimisation"[154] which deters complainants from finalizing their application.
- **Attrition of rape cases:** A study published in 2008 looked at 2,064 rape cases – trials commenced in less than one in five cases (17.3%) and only 4.1% of cases reported as rape resulted in convictions for rape.[155] If we consider table 9 above and compare the number of cases that resulted in conviction in 2011/2012 to the number of cases reported that same year this shows a conviction rate of 6.98% (and 4.5% in 2007/2008).[156]
- **Accessibility of the courts:** The working hours and consequent unavailability of court personnel, privacy at court, ill-trained and ill-equipped personnel, and accessibility for people with disabilities were also reported as an issue.
- **Domestic violence is not defined as a criminal charge in its own right**. Hence, it is difficult to collect reliable statistics and adapt programmes accordingly.
- **Governance and monitoring and evaluation challenges**
    - The DoJ faces challenges in obtaining data from the other departments and delays in submitting reports to the DG ISC "as a result of fragmented systems used in tracking interventions".[157]

[153] Vetten et al, 2010
[154] Watson, 2012
[155] Vetten et al, 2008
[156] Thorpe, 2013
[157] DoJ, 2012

- Multiplication of coordination structures with one piece of legislation (SOA) having four governance structures.
- The DVA was not costed, making it difficult to access sufficient funds for its implementation.
- Record keeping of domestic violence cases in courts is poor[158] and not standardized across courts.
- Some respondents felt that roles and responsibilities related to the SOA were not clear.

- **There were delays** at all stages of the procedures, because of very high caseloads.
- **Training:** Despite the various trainings organized by DoJ, and the three different types of training for the court clerks and the training of 347 clerks in 2010/2011,[159] with the NPA "clerks continue to be reported as ill trained and ill equipped"[160] and no performance monitoring mechanism is in place – including no indication of revision of training modules or on-going follow-up.
- **The NPF:** "According to some civil society organisations, the current NPF does not incorporate procedures to empower rape victims throughout the whole criminal justice system process, nor does it incorporate the role of CSOs in ensuring that rape victim rights are realised."[161]
- **Budgeting for roll-out of Sexual Offences Courts:** The amount earmarked for the roll-out of the first 22 courts falls short of the amount required for each court to be fully operational.[162]

Future plans

- **A process of amendment of the DVA started in 2012** but was put on hold. The challenges that the amendment is seeking to address include the costing of the act and defining a domestic violence criminal charge in its own right.
- If voted and adequately resourced and monitored, the NPF could respond to some of the challenges highlighted above. The NPF intends, among other goals, to eliminate secondary victimisation and implement "court reform initiatives to improve the rate of success in prosecution"[163]; develop on-going training courses accredited by SAQA, including on 'specialized skills'. However, the plan would have to be reviewed and aligned with other existing and overlapping plans, especially regarding "public and education and outreach strategy to educate the public on the Act and on services available to victims of SO"[164].

2.5 National Prosecution Authority

Mandate

The Sexual Offences and Community Affairs Unit (SOCA) within the NPA is specifically designated to deal with sexual offences. Established in 1999, the aim of this unit is "to reduce the victimisation of women and children by: enhancing the capacity to prosecute sexual offences and domestic violence cases; reducing secondary

[158] Watson, 2012
[159] Watson, 2012
[160] Ibid.
[161] Sonke Gender Justice E Newsletter, Issue 8; Keehn E. (not dated).
[162] Watson, 2013
[163] DoJ, 2013b
[164] Ibid.

victimisation of complainants and raising public awareness of the scourge of sexual offences and domestic violence; ensuring the proper management of young offenders".[165]

Achievements

- The NPA's main achievement is to have developed TTC centres: there were three in 2001 and 51 by 2013. Most of them are now funded by Treasury. They receive 10% more children than adults and 50% of the sexual offences survivors report to police;
- Other achievements include: The Ndabetiza Project on domestic violence, which trains traditional leaders, has developed a safety plan and public awareness raising campaign.

Table 10: Annual statistics for cases reported at TCCs

	2009/2010	2010/2011	2011/2012	2012/2013
Number of TTCs	25	45	52	51
Number of cases reported at TTCs	13 756	20 496	28 557	33 112
TTC cases received in court		9 716	10 949	7 708*
Cases finalised		1 716	2 180	2 248
Average conviction rate		63%	60.7%	61.03%

**** Excludes recycled and transferred cases in line with NPA indicator definitions***

In 2012, cases related to children constituted 57.6% of the cases reported in TTCs and 2,003 cases of domestic violence were reported.

The average conviction rate for the second quarter of 2013 has increased to 65.8%. However, this conviction rate is based on the number of cases that go to court, not on the total number of cases reported. Based on this, the conviction rate would be only 6.97%, mainly due to deficiencies within SAPS.

Challenges

- A lack of coordination between various stakeholders was reported. Specific examples include:[166] disagreements between NGOs running the Thuthuzela Care Centres (TCCs) and the NPA representative; lack of collaboration from medical doctors or police officers who do not make themselves available to attend to victims. Other coordination issues include inconsistencies in applying TTC services across the country and inconsistent funding to service providers.[167]

    - There was initially lack of funding within the SOCA unit to roll out more TTCs. However, Treasury has since institutionalised the TCCs and the NPA now receives funding for them.

    - Some TTCs have inadequate staff and material resources, including rape kits. Doctors working with victims are overextended and severely traumatised.

[165] http://www.npa.gov.za/ReadContent412.aspx sourced 8 September 2013.
[166] Interview respondents
[167] Round-table on Gender-based violence, 22 April 2013.

2.6 Department of Basic Education

Mandate

Schools constitute an opportunity to put in place preventative and protective interventions for children and to promote gender equality. The Department of Basic Education has a direct responsibility to ensure the safety of the child as part of the constitution of the country. Furthermore, our country is signatory to the Convention on the Rights of the Child, the Convention on the elimination of discrimination against women as well as the African Charter on the Rights and Welfare of the Child.

Response

The department has established several directorates that address issues of gender based violence; in particular the School Safety Directorate and Social Cohesion and Equity in Education Directorate address these issues. The response is multi-disciplinary and is underpinned by the ecological risk model on vulnerability to gender based violence. The main pillars of the department's response rest upon policy, programmes and advocacy.

Policies/Frameworks/Strategies

The department acknowledges that the structural drivers of gender based violence have to be addressed in order to accomplish sustained results. To this end the department has implemented pro-poor policies that have a protective impact on keeping girls in schools. Research has shown that the best social vaccine to protect girls from violence, including teenage pregnancy, is to educate them and keep them in schools. These policies include, among others, the implementation of no-fee paying schools and the national school nutrition programme.

The main drivers of gender-based violence are gender inequality coupled with poverty. The department is currently finalising several frameworks that contribute to addressing gender inequality. These are the Gender Equity Framework for Basic Education, the National Action Plan to combat racism and all forms of discrimination, and the National School Safety Framework. The department has finalised the DBE Integrated Strategy on HIV, STIs and TB, 2012-2016. These provide an enabling environment to implement programmes in a systematic and responsive way.

Programmes and tools

The department has several programmes that coalesce to provide a comprehensive response to gender based violence. These programmes have been institutionalised in the Curriculum and Assessment Policy Statements in the Life Orientation Curriculum across all grades and bands. The department uses a rights –based approach to addressing gender based violence.

The main programmes that address violence against women and children in education are as follows.

- **Guidelines for the prevention and management of sexual violence and harassment in public schools**

  The guidelines were developed as a response to the high levels of sexual harassment in schools. Teachers have been trained on the above guidelines in 2008 & 2009. The guidelines are on the department's website.

- **The Bill of Responsibilities (BOR): "Building a culture of humanity and accountability in schools"**

  This programme which is captured as Rights & Responsibilities in the Life Orientation Curriculum includes gender rights. The programme is supported by a Bill of Responsibilities that is premised on the Bill of Rights that each right comes with corresponding responsibilities. The programme is further supported by a teacher training manual that provides the content and activities for teachers to teach about rights and responsibilities. The programme has been supported by other departments and many of our partners, including Faith Based Organisations. Thus far all provinces have received training in the BOR.

- **Values in Action: A training manual in constitutional values and school governance for school governing bodies and representative council of learners in South African public schools.**

  School Governing Bodies (SGBs) and Representative Council of Learners (RCLs) are the champions of the ethos and policies of schools. The manual provides valuable information on the constitutional rights of learners including dedicated chapters on "Gender and sexual orientation", "Gender and sexual violence and harassment" and "Safe Schools". The manual has been used in the social cohesion training programme and to train SGBs and RCLs.

- **Social Cohesion Programme**

  The department has developed a social cohesion programme that is based on action research undertaken in different contexts in schools and communities. The aim of the programme is to make education a societal issue and for communities to come together to support the education of their children. Part of the programme focuses on developing a collective consciousness among different role players invested in education. The school is viewed as the hub around which the community begins to cohere. An integral part of the programme tackles gender norms and gender-based violence and provides school communities with the knowledge and skill to reflect and address gender based violence in the school and community. This component of the programme will be piloted and revised this year before it's implemented nationally.

- **The Integrated School Health Programme (ISHP)**

  The above programme provides health screening to identify barriers to learning and thereafter provides referrals and interventions. A component of the ISHP provides counselling and information on issues related to sexual abuse and Reproductive health. Thus far close to half a million learners have benefitted from the ISHP.

- **Life Skills, Sexual Reproductive Health and Peer Education Programmes**

  The most potent barrier to GBV is to inculcate in learners a positive sense of self that is supported by strong peers and good role models. The above programmes look specifically to utilising the agency of the youth to address their social challenges in a responsible and informed manner. To this end the department has developed guidelines on peer education and scripted lesson plans on life skills and sexual reproductive health which provides learners with the knowledge, skills and attitudes to address challenges including gender based violence. Thus far 18,039 educators were trained to implement sexual and reproductive health programmes for learners in 2012;[168] a total of 902,279 learner teacher support materials (LTSM) on sexual and reproductive health programmes were delivered to schools.

- **Gender Empowerment Programmes**

  Although the basic education sector has achieved gender parity and overwhelming access to education, the performance of girls in traditionally male dominated subjects continues to lag behind their male counterparts. The department therefore has partnered with other departments and external partners to

[168] DBE Annual Report 2012

support the THECHNO Girls programmes. The programme specifically targets young girls in the field of Science, Technology, Economics and Maths (STEM). Thus far close to 3500 girls have been given exposure to careers in these different fields and with future options to study bursaries based on their matric pass.

- The department also supports a UNICEF sponsored programme that targets the empowerment of girls and boys. The GEMBEM movement provides learners with the opportunity to harness their social capital as peers to positively impact on themselves and their communities. Part of the programme includes the formation of clubs and the participation in GEMBEM Jamborees that provide information on careers and life skills which has a strong gender bias.

Advocacy

The department has also utilised advocacy programmes to address Gender Based Violence such as Speak out Against Abuse.

- **Speak Out Against Abuse**

  The department has developed an advocacy programme for learners that inform them of their rights and the course of action if they are sexually harassed or raped. The advocacy programme is supported by a comprehensive and leaner friendly handbook entitled "Speak Out" Youth report sexual abuse-A handbook for learners on how to prevent sexual abuse in public schools. The advocacy programme utilises school dialogues and role playing to address gender based violence in schools. The booklet is distributed amongst the GEMBEM clubs.

- **Social Media**

  The department has created a learner focused website to support young people with understanding, preventing and reporting sexual abuse. The website address is *www.speakoutfreely.co.za* and went live in 2011. The website will further be used to highlight other issues of concern with regards to young people, including drug and alcohol abuse and school safety in general.

- **STOP RAPE Campaign**

  The Department in partnership with LeadSA embarked on the STOP RAPE Campaign as a response to the gruesome rape and death of Anene Boysens in 2013. The campaign raises awareness among learners on GBV, provides standardised messaging on sexual assault and scripted lesson plans for teachers to address rape. School assemblies have been specifically targeted as platforms from which the "Stop Rape Campaign" messages were aired, together with message activation on radio stations and print media. Furthermore, the department in partnership with MIXIT has made a "Stop Rape!" function available for learners and teachers with the support of Childline during the 1st March 2013 to 8th March 2013.

Challenges

- Despite the initiatives taken to tackle violence against girls at school, mainly through the development of manuals and training, the issue does not appear prominently in the DBE Action Plan to 2014. In fact, gender is mainly spoken of through the lens of teenage pregnancies and girls access to sciences.
- CSOs have drawn the government's attention to the pandemic of sexual violence in schools in recent months. Although policies and guidelines on how to deal with sexual offences in schools do exist, implementation remains inadequate and this has led CSOs such as Section 27 and the Legal Resources Centre to pursue legal cases.[169]

[169] Bornman et al, 2013

- Research has shown that girls who become pregnant (after rape or in other ways) are often discouraged from continuing their education, despite policy stances to the contrary. The latest statistics show that pregnancy accounts for about 8% of school drop-outs among teenage girls.[170]
- The Life Orientation Curriculum suffers a Cinderella status and is not always taken seriously by teachers. Teachers also require additional training to better question and redefine the gender norms and values they hold.
- There is no reliable data on the prevalence of GBV in schools and teenage pregnancies.

Future plans

- The review of the gender equality score will lead to the development of a Gender Action Plan that will be costed.
- Training on GBV across all provinces using an updated version of Opening Your Eyes: addressing GBV in South African Schools. Training of 450 masters to cascade programme to districts and schools.
- Gender responsive Frameworks developed and implemented.
- Online accredited course on gender based violence developed for teachers and accredited by SACE.
- Implement the partnership with Save the Children on developing the capacity of learners to address GBV.

2.7 Department of Women Children and People with Disabilities

Mandate

The DWCPD mandate has been defined as "promoting, facilitating, coordinating and monitoring the realisation of the rights and empowerment of women, children and people with disabilities"

Programmes and tools

The National Council against Gender Based Violence (NCGBV)

Inaugurated on 5 December 2011, the NCGBV is currently composed of an Executive Committee (EXCO) whose government and civil society members were appointed by the DWCPD Minister to provide strategic guidance to the Secretariat and to set up the Council, including developing governance structures and identifying priorities.

The idea is to set up the council according to the South African National AIDS Council (SANAC) model, with an elected board, a recruited Chief Executive Officer and an extended plenary chaired by the Deputy President. The plenary, chaired by the DWCPD Minister, would be composed of the IMC on the root causes of violence and a civil society forum. A Secretariat is also envisaged, as well as task teams that would be integrated in the Programme Implementation and Review Committee, which is chaired by a civil society member. The Council would also involve the private sector. Procedural guidelines have been developed.

[170] Ibid.

The objectives of the Council are to "provide high-level political leadership, strategic guidance and coherence of strategies across sectors to address the high level of GBV in South Africa; monitor and evaluate the execution of all gender-based violence interventions in the country; and mobilize resources"[171].

The Council envisages developing a national strategic plan and identified priorities under four pillars: communication and coordination, prevention, research and information, and support and response. The strategic plan would be accompanied by a costed action plan and involve civil society in its development and monitoring.

Other activities

Other VAW-related activities implemented by the DWCPD include the monitoring of international conventions and treaties, and the subsequent preparation of reports. The latest reports produced are to the UNECA in 2013 and to the Committee for the Elimination of Discrimination against Women (CEDAW) in 2011.

DWCPD is also responsible for the management of the 16 days of Activism against violence against women and the Orange Day Campaign.

Challenges

- CEDAW commented in 2011 that it was *"concerned about the weak institutional capacity of this Ministry, including inadequate human, financial and technical resources. It is concerned that such inadequacies could prevent it from effectively discharging its functions of promoting specific programmes for the advancement of women, effectively coordinating efforts among the different institutions of the National Gender Machinery at various levels, and ensuring comprehensive gender mainstreaming in all areas of government policy"*[172]. Most respondents interviewed shared this view.
- Interviews revealed that respondents had different understandings and interpretations of the roles and responsibilities, as well as accountability mechanisms, within the Council. In particular, the exact role of civil society in developing and monitoring the plan, as well as the role of the IMC. Other respondents felt that so far, the GBV Council consultation processes were unplanned and uncoordinated, both with civil society and the EXCO. It was also unclear to most respondents if decisions were made by the EXCO or by the DWCPD.
- In order to strengthen the coordination of CSOs and ensure they have a meaningful role in the Council, some respondents requested the creation of a Community Service Liaison Officer position.
- There is no long-term funding for the functioning of the Council.
- VAW-related initiatives and programmes are not located and centralized in one DWCPD Chief Directorate, partially because of capacity issues.

Future plans

- Mechanisms are being put in place to strengthen recruitment and selection processes as well as performance monitoring within DWCPD. A skills audit will also be conducted.

[171] DWCPD, 2013
[172] Committee on the Elimination of Discrimination against Women, 2011

2.8 Department of Health

Mandate

The Primary Health Care Package[173] outlines norms and standards for providing services to survivors of SV and IPV. The Domestic Violence Act does not set out any legal obligations for the DoH, but in the last two years the Department developed several guidelines and policy frameworks that frame its response. DoH plays a role in the implementation of the SOA through the provision of medico-legal services. DoH mandates include: providing Post Exposure Prophylaxis (PEP) to victims and HIV testing to people accused of rape, developing training courses on the SOA, participating in the ISC, and annual reporting.

The recently developedMental Health Policy Framework[174]was adopted the National Health Council in May 2013 and its operationalisation is underway.

Other frameworks were developed but not yet operationalized:

- **The 2012 National Policy on Rape, Sexual Assault and Other related Sexual Crimes** (written in October 2012) and **The National Management Guidelines for Rape, Sexual Assault and Other Related Crimes** seek to establish an institutional framework within DoH to guide other departments and ensure multi-sectorality and to establish designated care services, among other objectives. The policy comprehensively describes causes and consequences of sexual assault in South Africa, but some information contained within needs updating and the mechanisms of inter-sectoral collaboration should be clarified and updated in light of recent policy and programmatic developments in other departments.
- **The 2012 Integrated Strategic Framework for the Prevention of Injury and Violence in South Africa** is "an evidence-based platform for Government Departments to develop implementation and action plans" for primary, secondary and tertiary prevention of violence and injury. It aims to tackle the challenges of "inter-sectoral collaboration, fragmentation, and insufficient adaption of evidence in the planning, implementation and monitoring of interventions"[175] and is based on an analysis of the risk factors. Among the cross-cutting risk factors that need to be prioritised are gender inequality and dominant masculinity as well as alcohol and drug abuse. IPV is recommended as a focal area for prevention. Recommendations are also made on the institutional environment that should drive prevention efforts. The framework defines 12 objectives and is calling on other departments to develop their own strategic plans. The framework still needs to be approved by Cabinet.
- **The draft National Health Sector Strategic Plan for Injury and Violence Prevention 2013 to 2016** is the adaptation of the Integrated Framework for the DoH. It is expected to be published in March 2014.
- DoH has also started drafting a comprehensive **implementation plan on GBV** that will compile all the VAW-related obligations and activities presented in DoH's policies and guidelines.

Other initiatives and achievements

- DoH has developed **designated health centres for victims of sexual assault and related offences(rape)**. They follow the TTC model and provide comprehensive support to victims of rape, ensuring that they receive services from a social worker, a police officer, the NPA and a psychologist. The approach is

[173] Primary Health Care Package, 2000.
[174] DoH annual Report 2012
[175] Presentation of the Framework to the Technical Advisory Committee, 14/06/2013

localized, based on an identification of existing specialized services around the medical facilities, such as SAPS Family Violence, Child Protection & Sexual Offences Unit (FCS). Dedicated staff from various departments are on call 24 hours per day and available when a victim needs assistance and a trained nurse is in the centre at all times. They are currently 233 in the country.

- **The DoH has developed a national curriculum on post-rape care.**
- The IMC mandated DoH to use health facilities as entry points for SV victims. A tool was designed to assess designated facilities and TTCs and to improve their functioning, in particular improving collaboration between departments. The idea is to develop one model of one stop centres in more than 1,000 health facilities around the country.
- The number of people trained are as follows:

Table 11: Training of Health Professionals in the management of sexual assault and related crimes

Province	2008	2009	2010	2011	2012	2013
Eastern Cape	50 nurses 0 doctors	NIL	NIL	65 nurses 3 doctors	160 nurses 3 doctors	50 nurses 2 doctors
Free State	40 nurses 0 doctors	NIL	NIL	116 nurses 0 doctors	176 nurses 20 doctors	82nurses 13 doctors
Gauteng	60 nurses 0 doctors	NIL	14 nurses 0 doctors	37 nurses 2 doctors	134 nurses 10 doctors	38 nurses 7 doctors
Kwa-Zulu Natal	NIL	60 nurses 0 doctors	55 nurses 3 doctors	NIL	141 nurses 15 doctors	60 nurses 12 doctors
Limpopo	NIL	103nurses 0 doctors	NIL	NIL	150 nurses 0 doctors	38 nurses 3 doctors
Mpumalanga	40nurses 0 doctors	NIL	NIL	30 nurses 0 doctors	134 nurses 3 doctors	25nurses 2 doctors
Northern Cape	40nurses 0 doctors	NIL	NIL	NIL	75 nurses 0 doctors	32 nurses 2 doctors
North West	40nurses 0 doctors	NIL	NIL	27 nurses 4 doctors	86 nurses 8 doctors	62nurses 6 doctors
Western Cape	NIL	NIL	NIL	50 nurses 0 doctors	50 nurses 0 doctors	33 nurses 4 doctors
TOTAL	**270 nurses 0 doctors**	**163 nurses 0 doctors**	**69 nurses 3 doctors**	**325 nurses 9 doctors**	**1106 nurses 59 doctors**	**420 nurses 51 doctors**

Challenges

- At present, key respondents interviews indicated that secondary victimisation is taking place both in TTCs and DoH facilities, and quality standards are not uniformly implemented.
- Not enough mental health care practitioners are available to provide adequate mental health care services to survivors or service providers.

Future plans

DoH is planning to:

- Conduct a national audit of the availability of and adherence to the PEP regimen (2013/2014);
- To increase the number of health facilities offering a package of SV services to 100% by 2015;
- Train health professionals in the management of SV to achieve 100% by 2015;
- Roll out early childhood home visitation by Community Health Workers (CHW), train parents, and train health care workers to detect child abuse and maltreatment;
- Scale up access to mental health care.

2.9 Coordination

A duplication of government coordination structures was reported during key informant interviews, with various departments developing inter-sectoral strategies, policies or action plans and putting in place different coordination forums that largely overlap.

> "The various coordination committees do not talk to each other. The result is duplicated programmes and at the end of the day, we say we do not have the resources."

> "I am concerned about overlaps and lack of synergies."[176]

This duplication is partially rooted in the legislative and policy mandates of the departments. No clear links are made between the coordination structures or the plans they produce; they do not all have detailed action plans and solid M&E frameworks; and roles and responsibilities and lines of accountability are often unclear. It is not obvious who should ensure overall coordination, monitoring and accountability. Respondents had divergent opinions on this, mentioning that this role should be endorsed by DWCPD, the Department of Performance Monitoring and Evaluation (DPM&E) Department or DSD.

This situation has several consequences, with officials being requested to attend "too many meetings" and topics being discussed in parallel forums. Various respondents indicated losing interest and stopping attending these meetings, as they "would rather concentrate on what [their] department can do";[177] this means decision makers are often not represented in forums and decisions postponed. Another consequence of the lack of overall coordination is that different coordination structures have developed multi-sectoral VAW Action Plans –DSD produced the VAW prevention programme, the GBV Council is planning to develop a VAW Strategy, and the IMC on VAW has produced a Programme of Action with DoH. Other examples include the Integrated Strategic Framework for the Prevention of Injury and Violence in South Africa and some respondents cited the 365 Day Plan developed in 2007 by the IDMT (interdepartmental management team). It is not clear whether there is any intention to merge or link these various plans.

Mistrust between government and CSOs was also reported as an issue by the majority of respondents. Civil society has not participated fully in the development of any of the plans mentioned above and civil society respondents reported they feel that the consultation mechanisms were not efficient and there was an

[176] Various Interview respondents
[177] Interview respondent

insufficient strategic use of civil society's specialist skills. Some NGOs have built successful relationships with individual government departments based on targeted areas, such as training, and the success is often based on personal good relations between the NGO and government representatives.

Lack of coordination within the NGO sector, brought about by competition for funding, was also noted as an issue.

In spite of the existence of a Donor Coordination Forum coordinated by the DWCPD, several respondents pointed to the lack of coordination between donor and UN agencies that at times contributed to the duplication of initiatives through the funding of similar projects or programmes in different departments.

An innovative initiative is the **Joint Gender Fund**, a mechanism constituted in 2008 by HIVOS, Ford Foundation and Irish Aid (with CIDA and SIDA joining later). This mechanism enables donors to pool funding, develop a common strategy and fund NGOs through a tendering process. Positive impacts of this Fund include improved focus on strategy rather than operations; increased results due to increased budget and decreased transactional costs; scaling up of good practices such as the Image Intervention that was initially implemented in Limpopo and is now happening in KwaZulu-Natal. The Fund also organizes dialogue between civil society and government departments to create opportunities to develop synergies. Recent dialogue led to a Draft Manifesto, developed by SAPS, the Civilian Secretariat for Policing and the Joint Gender Fund, which is proposing a community-level strategic tool for responding to VAW.

The way forward envisaged by DSD and DWCPD in terms of overall coordination is that the VAW IMC would be integrated in the GBV Council. Respondents had different views on the Council governance structures and on who would ensure overall accountability. They also had different views on the planning process, some considering that the IMC's Five Year National Action Plan on Violence would be located in the GBV Council while others, from civil society and government, felt the overarching plan should be developed by civil society using the process that was used to develop the National Strategic Plan on HIV, STIs and TB (NSP). NGOs also recommended for the Council to have a Civil Society Liaison Officer who would support better coordination among civil society.

2.10 Mapping of the NGO responses

CSOs are the biggest provider of services in the field of VAW primary and secondary prevention.

- **Primary prevention** relates to the prevention of VAW before its occurrence and should address the risk factors of VAW.
- **Secondary prevention** relates to responses once VAW has occurred and includes emergency medical care, shelter services and counselling, and legal services. It encompasses victim responses and responses to perpetrators so that further harm to the victim and re-offence can be prevented.
- **Tertiary prevention** refers to long-term responses and is generally targeted at rehabilitating perpetrators and survivors.

A multitude of national NGOs and local Community Based Organisations (CBOs) engage in SBCC, advocacy and lobbying, training and support services. These activities are directed to the general public, government and to survivors.

It was beyond the scope of this report to identify and analyse the programmes of all the organisations involved in this field. Key organisations were selected, following a consultation with the research task team members.

Based on internet searches and questionnaires sent to 29 organisations, the mapping exercise aimed to determine the types of programmes implemented (and in particular the balance between primary and secondary interventions); their reach and geographic coverage; the number of evaluations conducted and the results thereof; as well as the CSOs' programme implementation budget. In doing so, the mapping sought to uncover the main VAW response efforts as well as identifying the gaps. However, the low response rate to the questionnaire (seven were returned) did not allow for analysis of the reach, programmatic evaluations and budgetary aspects of the services rendered.

The table below presents a picture of the common types of activities implemented by the selected NGOs as well as the specific topics tackled and interventions implemented in the areas of primary and secondary prevention.

Darker colours indicate activities and services which more prominent, whereas the lighter they become, the fewer organisations providing those services.

Table 12: Scope and focus of NGO prevention and support activities

Name of NGO	Type of Activities: SBCC	Advocacy and lobbying	training	Support to access services	Other	Scope and focus of NGO prevention and support activities: Primary prevention of violence: social norm change on gender/ GBV	gender attitude change	changing men's behaviour to be more equitable & less violent	strengthening early/older years parenting	addressing poverty & delinquency in adolescent boys	violence prevention through alcohol abuse reduction	promoting economic empowerment of women & girls	enhancing educational attainment for girls/women	school GBV prevention programmes	Responses (Secondary Prevention): counselling and support for survivors	strengthening access to justice	strengthening health services	shelters	strengthening child protection	Provinces working in	Towns
API			x						x											WC	CT
CASE	x		x				x	x							x					WC	Athlone, Hanover
CICP	x	x	x				x	x		x				x						WC, NC	CT, UPTN
CSVR	x	x	x	x								x		x		x				GP, WC	JHB, CT
CWD WIN	x			x				x	x		x		x		x					WC	CT
FAMSA			x			x	x		x						x	x			x	National	All provinces
Genderlinks	x	x	x								x						x			National	National
GRIP	x	x		x											x	x	x			MP	
HOC			x						x			x			x			x		GP	JHB
loveLife	x	x	x	x											x		x			National	
Marie Stopes					x												x			National	National
Masimanyane	x	x	x			x									x	x	x			EC	EL, KW
Molo Songolo	x	x	x	x										x	x	x		x		WC	BW, Atl,DFT
Mosaic TSHC	x	x	x	x				x							x	x				WC	CT
Nisaa	x	x	x	x		x	x	x				x	x		x	x	x			GP	SWTO,LN

Name of NGO	Type of Activities: SBCC	Type of Activities: Advocacy and lobbying	Type of Activities: training	Type of Activities: Support to access services	Type of Activities: Other	Primary prevention of violence: social norm change on gender/ GBV	Primary prevention of violence: gender attitude change	Primary prevention of violence: changing men's behaviour to be more equitable & less violent	Primary prevention of violence: strengthening early/older years parenting	Primary prevention of violence: addressing poverty & delinquency in adolescent boys	Primary prevention of violence: violence prevention through alcohol abuse reduction	Primary prevention of violence: promoting economic empowerment of women & girls	Primary prevention of violence: enhancing educational attainment for girls/women	Primary prevention of violence: school GBV prevention programmes	Responses (Secondary Prevention): counselling and support for survivors	Responses (Secondary Prevention): strengthening access to justice	Responses (Secondary Prevention): strengthening health services	Responses (Secondary Prevention): shelters	Responses (Secondary Prevention): strengthening child protection	Provinces working in	Towns
OLF		x	x												x				x	WC, GP, KZN,EC	
OUT	x	x		x												x	x				
POWA	x	x	x			x	x					x			x	x		x		GP	JHB
Rape Crisis	x	x	x	x									x		x	x				WC	CT
Reaching Out	x	x	x	x				x					x		x	x		x		KZN	RB
SANCA	x	x	x	x							x				x	x				National	National
Sonke Gender Justice Network	x	x	x	x		x	x	x									x			WC, GP, MP	CT, JHB, BBR
Soul City	x	x	x	x		x	x	x	x	x	x	x	x						x	WC	
SAMGI		x	x									x	x		x		x	x		WC	CT
TVEP	x	x	x												x	x	x			LP	THYO
Trauma Centre for Survivors of Violence & Torture			x	x											x					WC	CT
TLAC		x	x	x											x	x		x		GP	JHB
WLCE		x		x		x								x		x		x		WC	CT
Women's Net		x	x	x	x	x	x					x	x			x			7	GP	JHB
Total out of 29	**18**	**22**	**24**	**17**	**3**	**11**	**7**	**8**	**5**	**2**	**4**	**7**	**7**	**4**	**19**	**16**	**12**	**8**	**8**		

*Note– OUT implements its activities in partnership with other NGOs such as the Triangle Project, the Gay and Lesbian Archive, the Forum for the empowerment on women, Gender Dynamics; Gala, Few, Durban Gay and Lesbian Centre, Pietermaritzburg Gay and Lesbian Network.

API	The Aware Parenting Institute	SAMGI	South African Media Gender Institute	NC	Northern Cape
CASE	Community Action towards a Safer Environment	TVEP	Thohoyandou Victim Empowerment Programme	BW	Beaufort West
CJCP	Centre for Crime Prevention	TLAC	Tshwaranang Legal Centre	ATL	Atlantis
CSVR	Centre for the Study of Violence & Reconciliation	WLCE	Women's Legal Centre	DFT	Delft
CWD WIN	Catholic Welfare & Development, Women in Need	GP	Gauteng Province	SWTO	Soweto
FAMSA	Family South Africa	MP	Mpumalanga	LN	Lenasia
GRIP	Greater Nelspruit Rape Intervention Programme	EC	Eastern Cape	BBR	Bushbuckridge
HOC	Hands of Compassion	KZN	KwaZulu-Natal	UPTN	Upington
MOSAIC TSHC	Mosaic Training, Service & Healing centre	WC	Western Cape	KW	King Williams Town
Nisaa	Nisaa Institute for women's Development	JHB	Johannesburg		
OLF	Olive Leaf Foundation	CT	Cape Town		
POWA	People Opposing Women Abuse	EL	East London		
SANCA	South African National Council on Alcoholism & Drug Dependence	LP	Limpopo		

List of Acronyms for table of NGO programmes above.

Types of activities

Training, advocacy and lobbying are the most commonly offered activities (cited 24 and 22 times respectively). SBCC programmes are offered by just over half of the organisations surveyed (18 out 26).

Secondary prevention

The data shows that the majority of NGOs provide secondary prevention responses to violence. More specifically, the data shows that most of these organisations offer counselling and support services and strengthen access to justice for survivors (19 and 16 respectively). These are followed by the strengthening of health services (12).

Primary prevention

Primary prevention efforts on the other hand are among the least offered response interventions by NGOs. Within these interventions, social norm change on gender/VAW appears to be the most prominent form of primary interventions offered. However, it is offered by less than half of the organisations surveyed (11 out of 26). This is followed by changing men's behaviour to be more equitable and less violent (8) and thereafter gender attitude changes (7) and the promotion of economic empowerment/educational achievement of women and girls (7).

Moreover, only a few of the organisations' primary prevention response efforts are around strengthening parenting, violence prevention through alcohol abuse reduction, and addressing poverty and delinquency in adolescent boys.

Discussion

It is important to note that the reach of the SBCC and school-based programmes from organisations such as Soul City or Love Life is national and targets a large volume of people, hence the comparative importance of these programmes should not be evaluated based on this table.

However, there is a clear imbalance between primary and secondary prevention activities. Most of the CSO efforts appear to focus on strengthening the criminal justice system by supporting survivors' access to services, and providing counselling services as well advocacy and lobbying. The most common type of activity is training programme beneficiaries, organisational staff and volunteers as well as advocacy and lobbying to government departments. In fact, this result confirms the central role of the NGOs in implementing the SOA and DVA and filling in gaps in implementation of these acts, in particular providing psychological services, ensuring referrals and in making services available and lobbying government departments.

In terms of primary prevention, it is encouraging to note that nearly half of the organisations work on changing social norms on VAW, and slightly over one quarter work towards promoting economic empowerment of girls and enhancing educational attainment – proven protective factors against IPV. This is important because, as shown in the analysis of the risk factors above, interventions that do not seek to address social norms and challenge patriarchal values are likely to have serious constraints and unlikely to lead to social change.

The geographical reach of the organisations reveals that the majority of the interventions are concentrated in Western Cape (10) and Gauteng (7), with seven NGOs having national reach. However, only two organisations worked in Eastern Cape, KwaZulu-Natal and Mpumalanga and only one in Limpopo. Although this table does not represent all organisations implementing VAW activities (especially small CBOs or NGOs managing shelters) it appears that beyond national programmes, there is a high concentration of activities in urban areas. This finding is consistent with other research on the topic.

Finally, only three organisations sent an evaluation and none of them measured change at outcome level. Evaluations are discussed in more details in section 2.12 below.

2.11 Mapping of Social and Behaviour Change Communication interventions

Defining Social and Behaviour Change Communication

There has been a recent shift in terminology from Behaviour Change Communication (BCC) to SBCC, due to a growing understanding that behaviours are grounded in a particular socio-ecological context and change usually requires support from multiple levels of influence.[178] The addition of an 'S' to BCC aims to raise awareness of the need for systematic, socio-ecological thinking within communication initiatives.[179]

SBCC is the "systematic application of interactive, theory-based, and research-driven communication processes and strategies to address tipping points for change at the individual, community, and social levels".[180] SBCC programmes aim to improve people's knowledge and skills, influence their beliefs and attitudes, challenge existing and prevailing norms, and bring about social support and influence. These factors are also known as ideational factors. SBCC programmes are designed to directly impact on ideational factors, with the hope that it will result in a change of behaviour. At the same time these programmes provide critical knowledge and skills to people that may influence their norms and values and enable them to take action.[181]

SBCC encompasses a number of different approaches which operate at different levels within the socio ecological model. These include: mass media, small media, interpersonal communication (IPC), advocacy and social mobilization.

SBCC programmes in South Africa

There are relatively few SBCC initiatives which address VAW in South Africa. Table 15 below describes the SBCC programmes which address VAW and GBV. While some SBCC programmes, such as 16 Days of Activism and White Ribbon South Africa, address VAW as their primary outcome, many of the programmes address GBV within the context of the HIV response.

[178] Defining Social and Behaviour Change Communication (SBCC) and other essential health communication terms. Technical Brief. The Mantoff Group.
[179] Leclerc-Madlala, 2011
[180] FHI 360, 2012
[181] Kincaid, 2010

Table 13: Social and Behaviour Change Communication Programmes addressing VAW and GBV in South Africa[182][183]

SBCC programme	Description	Scale	Partners	Time frame	Approach					Evaluation
					Mass media	Small media	IPC	Advocacy	Social mobilization	
16 days of Activism	The 16 Days Campaign for No Violence against Women and Children is an international campaign that originated from the first Women's Global Leadership Institute in 1991.	International	United Nations, Government, NGOs, CBOs and other stakeholders	Running in SA from 1999 to present	√	√	√	√	√	Yes. Methods: 1) Tracking study – nationally representative sample of 2,400 people aged 18 or older per quarter and 2) Consultative workshop, literature review, individual and group interviews, and focus group workshops.
365 days of Activism	This is a sustained prevention and awareness campaign targeting men and women that extends the 16 Days of Activism into a year-long campaign. It involves women and men across the country. In 2006, the campaign adopted a rural focus and an emphasis on the participation of men and the boy child.	National	260 representatives from all spheres of government; constitutional bodies; civil society; business; unions; FBO[182]		√	√	√	√	√	
Stop the Bus	Took a busload of volunteer trainers, community activists and counsellors on a tour of Western Cape's rural areas offering workshops, networking meetings, training and counselling on issues relating to VAW.	Provincial	The Rape Crisis Cape Town Trust, WOMANKIND Worldwidee[183]	2006		√	√	√	√	x

[182] And traditional authorities and international cooperating partners.
[183] And the Western Cape Network on Violence Against Women, the Gender Advocacy Project, Women on Farms.

Brothers for Life	Brothers for Life targets mainly men over 30. The campaign seeks to address the risks associated with having multiple and concurrent partnerships, sex and alcohol, GBV and promotes HIV testing, male involvement in PMTCT and general health seeking behaviours.	National	SANAC, Department of Health, USAID/ PEPFAR, JHHESA, Sonke Gender Justice, UNICEF, UN[184]	August 2009 - present	√	√	√	√	√	Yes. Evaluated as part of the Third National HIV Communication Survey – a nationally representative survey of 10,034 respondents aged 16-55 years.
IMAGE[185]	IMAGE combined a microfinance programme for women with participatory training on understanding HIV, gender norms, domestic violence, and sexuality	Eight villages of LP					√			Yes. Randomized control trial.
loveLife	GBV prevention programme	EC WC	Government Departments in Eastern and Western Cape		√	√	√	√	√	Yes. Evaluated as part of the Third National HIV Communication Survey (see above)
One in Nine Campaign	The One in Nine Campaign is a feminist collective which supports survivors of sexual violence			February 2006 - Present				√	√	
One Man Can (OMC) Campaign	The One Man Can Campaign supports men and boys to take action to end domestic and sexual violence and to promote healthy, equitable relationships that men and women can enjoy - passionately, respectfully and fully.	National	Sonke Gender Justice; DoH; COGTA; TAC; POWA; The South African Football Players Union; Targeted AIDS Interventions[186];	2006	√	√	√	√	√	Phone surveys with OMC Campaign participants and routine data from government and NGO sources in three provinces. Qualitative research project underway in seven provinces with participants in the broader OMC Campaign.

[184] And more than forty HIV prevention and health CSOs.
[185] Intervention with Microfinance for AIDS and Gender Equity (IMAGE).
[186] And The International Coalition for Women's Health; the Commonwealth Secretariat; the Family Violence Fund and Instituto Promundo.

Shukumisa	Coalition of organisations from around the country working to combat sexual violence	National	Adapt, Childline SA[187]	2008		√		√	√	x
Soul City Series 4	Soul City 4 television series highlighted the issue of VAW in Southern Africa. It was bolstered by a daily radio drama, full-colour booklets, an advertising/publicity campaign, and an advocacy and social mobilization campaign, in an effort to shift knowledge, attitudes and practices around GBV	National	National Network on Violence Against Women (NNVAW); DoJ and Lifeline.	1999- 13 episodes	√	√		√	√	Baseline survey conducted as a pre-test in June 1999 to measure a range of conducts before the radio and TV series were broadcast. A second (evaluation or post-test) survey was conducted on a different sample in February 2000, shortly after Soul City 4 went off air (aim: to measure the same constructs, compare the responses in the two surveys, identify changes, and assess whether any of these could be attributed to Soul City interventions).
Stepping Stones	Stepping Stones is a 30-hour programme, which aims to prevent violence and improve relationships and sexual health by using participatory learning approaches to build knowledge, risk awareness, and communication skills and to stimulate critical reflection. It is facilitated using a manual to single-sex groups.	?		?			√			Yes. Cluster randomized controlled trial conducted in 70 villages in rural Eastern Cape.

[187] As well as: Community Law Centre Parliamentary Participation Unit, eMPathy trust Southern Africa, FAMSA Pietermaritzburg, Gender Health and Justice Research Unit (GHJRU), Greater Rape Intervention Project (GRIP), Justice and Women (JAW), Legal Resources Centre, Lethabong Legal Advice Centre, Lifeline/Rape Crisis Pietermaritzburg, Limpopo Legal Advice Centre, Masimanyane Women's Support Centre, Mosaic, Nisaa Women's Support Centre, Peddie Women's Support Centre, People Opposing Women Abuse (POWA), Project Empower, RAPCAN, Rape Crisis Cape Town Trust, Remmoho, Teddy Bear Clinic, Sonke Gender Justice Network, Sex Worker Education and Advocacy Taskforce (SWEAT), Thohoyandou Victim Empowerment Programme, Thusanang Advice Centre, Tipfuxeni Community Counselling Centre, Tshwaranang Legal Advocacy Centre, Western Cape Network on Violence Against Women, Women on Farms Project, Women's Legal Centre

White Ribbon South Africa	White Ribbon is the world's largest male-led movement to end men's VAW. It seeks to change attitudes and behaviours that lead to and perpetuate men's violence against women by engaging men and boys.	International. over 65 countries	White Ribbon South Africa; Brothers for Life; Primark; The Hook Up Dinner; Boxer	May 2013 - present	√	√	√	√	√	x

Evaluating SBCC interventions

Of the 12 SBCC interventions addressing VAW and GBV described above, only seven have been evaluated (or have made their evaluations available to the public). The methods and rigour of these evaluations varies widely: from those which focus primarily on measuring reach of the interventions to those which attempt to draw causal inferences. Relatively few interventions which aim to prevent or respond to GBV have been rigorously evaluated i.e. measuring outcomes at behavioural and attitudinal levels, in particular demonstrating actual reductions in levels of domestic violence. A few evaluations measure association between exposure to intervention components and attitudes and behaviours that are considered as intermediary factors towards social change. A SBCC Programme Evaluation Case Study is presented in Annexure 3 (Evaluation of Soul City Series 4).

Emerging evidence was found of the effectiveness of programmes involving men, but no evaluation was found that showed reductions in levels of domestic violence. For example, the evaluation of the One Man Campaign implemented by Sonke Gender Justice in South Africa showed improved levels of reporting violence among the men enrolled.

Despite the paucity of rigorous evaluations of SBCC interventions addressing VAW in South Africa, there is evidence to suggest that SBCC interventions can influence intermediary factors such as knowledge, attitudes and self-efficacy as well as actual behaviour:

- Evidence from the HIV field proves that well-designed mass media communication programmes can influence behaviour such as condom use at last sex and uptake of HIV counselling and testing.[188]
- Two randomized-control trials, internationally acknowledged and implemented in South Africa, proved the links between interpersonal communication interventions (which include economic and social empowerment of women) and decreased IPV. They are described in more detail in the section on good practice below.
- Comprehensive, multi-faceted interventions, such as Soul City 4, impact on intermediary factors such as knowledge, attitudes and self-efficacy,[189] with a 10% increase in respondents disagreeing that domestic violence was a private affair – qualitative data analysis suggests the intervention played a role in enhancing women's and communities' sense of efficacy, enabling women to make more effective decisions around their health and facilitating community action.

2.12 Identified prevention good practices

The literature review and interviews indicated that few approaches to preventing or responding to VAW have been rigorously evaluated by government departments or CSOs. When they exist, the evaluations generally do not measure outcomes at behavioural and attitudinal levels, and in particular do not demonstrate actual reductions in levels of violence. However, a few intervention evaluations have measured association between exposure to intervention components and behaviours. These interventions can be considered as good practices and the two randomised-controlled trials implemented in South Africa are described below.

[188] Johnson et al, 2010
[189] Usdin et al, 2013

The **Intervention with Microfinance for AIDS and Gender Equity (IMAGE),** implemented in eight villages in Limpopo province combined a microfinance programme for women with participatory training on understanding HIV infection, gender norms, domestic violence, and sexuality. After two years, the risk of past-year physical or sexual violence by an intimate partner was reduced by more than half. Reductions in violence resulted from a range of responses enabling women to challenge the acceptability of violence, expect and receive better treatment from partners, leave abusive relationships, and raise public awareness about IPV.[190]

Stepping Stones, a 30-hour programme, aims to prevent violence and HIV, improve relationships and improve sexual health by using participatory learning approaches to build knowledge, risk awareness and communication skills, and to stimulate critical reflection. Villages were randomized to receive either this programme or a three-hour intervention on HIV and safer sex. The Stepping Stones intervention showed a 40% reduction in VAW perpetration sustained for two years. It also showed a lower proportion of men reporting transactional sex and problem drinking at 12 months.

A pilot intervention combining the Stepping Stones programme with an economic empowerment programme (Creating Futures), implemented by the MRC and Heard, demonstrated significant impact similar to the IMAGE study results. Women reported a reduction in their experience of sexual or physical IPV in the past three months from 29.9% at baseline to 18.9% at 12 months; men's and women's incomes in the past month increased substantially.[191]

Despite the strong evidence related to these two interventions, only the IMAGE intervention has been scaled-up.

Conclusion

Does the response address VAW effectively and comprehensively?

The section below presents "recommended indictors to measure the effectiveness of the State response", validated by UN women and based on the Report of the Special Rapporteur on violence against women, its causes and consequences.[192] Below each indicator, the South African situation, as described in the sections above, is summarised and the gaps in the response identified.

Indicator: Ratification of the Convention on the Elimination of Discrimination against Women and other human rights instruments and Constitutional guarantees of women's equality and repeal of discriminatory laws.	
	South Africa has ratified CEDAW and women's equality is guaranteed by the Constitution.
Indicator: An effective legal framework, statute and procedural law that provides access to justice, redress, protection and compensation.	

[190] Pronyk, Image evaluation.
[191] http://www.heard.org.za/gender/creating-futures-stepping-stones accessed on 27/10/2013
[192] Ertürk, 2008

	The DVA and SOA provide access to justice, protection and compensation, but their implementation is not sufficiently funded. The governance mechanisms guiding the implementation of the legal framework are not entirely effective. The DVA does not place any obligations on DSD, DoH or DBE.
Indicator: Criminalization of all forms of violence against women and the prosecution of its perpetrators.	
	Forms of violence are criminalized but under-reporting is high and conviction rates are low.
Indicator: A plan of action/executive policy on violence against women with a strong evidence base and political will for its implementation, demonstrated by budgetary allocation, timelines and clear paths of responsibility.	
	There are several multi-sectoral plans of action guiding the response to VAW but no overarching plan endorsed by all stakeholders or clear lines of accountability. There is a duplication of coordination forums. Plans and programmes are not systematically based on evidence and there are not enough evaluations. Budget allocation to VAW is insufficient. Good coordination initiatives exist, however, through the Joint Gender Fund.
Indicator: Increased awareness and sensitivity of professionals and officials.	
	Government officials are trained, but there is no evidence of the quality and effectiveness of the training. Very few government departments could provide data on number of people trained and none provided evidence on the impact of the training.
Indicator: Resource allocation to ensure provision of support and advocacy services by NGOs, including shelters, helplines, advocacy, counselling and other services.	
	The resource allocation to NGOs is insufficient and inconsistent and relies heavily on donor funding. There is a consequent lack of funding to shelters and to support and advocacy NGOs. The role of NGOs in the development and monitoring of the plans is unclear.
Indicator: Awareness-raising and prevention programmes.	
	Awareness-raising campaigns exist but are not rigorously evaluated. Evidence of effective prevention interventions exists, but they are not scaled up. Prevention interventions are not systematically linked to VAW risk factors and consequences.
Indicator: Addressing structural inequalities in the promotion of women's advancement.	
	There are contradictory efforts to address structural inequalities, patriarchal values are still influential in society but coexist with innovative organisations working to redefine gender norms. A paradigm shift from gender equality to women's vulnerability was noted in the latest legal frameworks, the latter positioning women as passive recipients in need of support instead of active rights holders. *The discussion on risk factors showed the need to address societal-level factors such as patriarchy to effectively prevent VAW – more efforts on this are needed in South Africa*
Indicator: Collection, collation and publication of data, including evaluation of policies and basic research programmes.	
	Data collection and publication sites are scattered among NGOs and research institutes, and need to be centralized in one accessible point.

Recommendations

The section below presents recommendations for policy makers, donors, programme implementers as well as researchers. The recommendations respond to the research questions proposed by the DWCPD and UNFPA in the Study ToR. They identify interventions that need to be prioritised as well as ways to increase the effectiveness of existing programmes and of SBCC campaigns. The recommendations also look at improving coordination; identify research areas and propose improvements for the collection and analysis of VAW data.

These recommendations are not prioritised and do not specify roles and responsibilities for implementation, as this was beyond the scope of this report. Rather, it is expected that these recommendations will be discussed and prioritised during a consultative workshop gathering key VAW stakeholders in South Africa. It is expected they will further be translated into a national VAW Action Plan.

Which types of intervention should be prioritised?

The analysis of VAW risk factors shows the interconnection between them. The good practices presented have demonstrated that interventions are much more effective when they target multiple risk factors and operate at multiple levels. Based on this, we present intervention targets and examples of related programmes that seek to prevent VAW by tackling the risk factors at all levels of the WHO ecological model and that have been proven effective.[193]

Interventions to change social norms around masculinity and gender relations: The discussion above has clearly highlighted the role of social norms around gender relations and ideals of masculinity in the risk of men and boys perpetrating VAW. An essential focus for intervention is to change these norms at a societal or community level, and also at an individual level.

> *Examples of intervention: School-based programmes, life skills interventions; programmes directed at men to change gender social norms (Stepping Stones); microfinance programmes with gender training (IMAGE and Stepping Stones with Creating Futures); enhancing women's entry to tertiary education and employment.*

Interventions to change social norms around the use of violence: An important part of VAW prevention involves reducing the social acceptability of VAW and the use of violence in social relations more generally. A critical part of the social learning here occurs in childhood and so reducing the use of corporal punishment at home and in school (where it is illegal but widely practiced) is essential. In addition, the clearly researched link between public and private violence shows that "prevention of domestic violence is essential both in its own right and as part of efforts to reduce broader violence and crime in society".[194] This means that interventions that effectively reduce societal levels of IPV may also have an important impact on other forms of violence.

> *Examples of intervention: Enforcing laws on corporal punishment and training teachers on positive discipline; strengthening the Firearm Control Act of 2000.*

Reducing the propensity for men to be aggressive, impulsive and remorseless through interventions in childhood: Reducing exposure to all forms of adversity in childhood is essential for reducing perpetration of

[193] Heise L. 2011 and UNFPA, undated
[194] Abrahams, 2005

violence, including the most severe violence perpetration. In order to achieve this it is necessary to change social norms around parenting to enhance perceptions of the responsibility of both parents for child protection, to reduce the use of violence in parenting (especially of young children), to enhance understanding and the use of appropriate non-violent discipline, and to improve communication and engagement with children.

Child protection systems must be better resourced and able to identify vulnerable children and families and effectively act to protect them.

Examples of intervention: Parenting programmes; screening and treatment for maternal depression; secondary prevention programmes with young survivors of violence to avoid victimisation; implementation of the child protection measures in the Children's Act.

Reducing teenage male school dropout, unemployment and underemployment: Interventions to enhance the involvement of teenage boys and men in gainful employment, study and recreation are critical for reducing the propensity of teenage boys and young men to hang out in contexts where they may engage in violent and antisocial behaviour.

Examples of intervention: To promote positive masculinities with young men; youth employment programmes; prevention and early identification of vulnerable children, tertiary prevention programmes with perpetrators.

Reducing binge drinking: Interventions to reduce binge drinking are an important part of the overall agenda for VAW prevention.

Examples of intervention: Interventions with problem drinkers; development of legislation regulating sale of alcohol and raising alcohol prices; interventions in alcohol-serving venues; measures to ensure safety around alcohol-serving venues; development of other socialization venues.

Enhancing relationship skills: Interventions that build relationship skills and respect between men and women have an important role in reducing conflict in relationships and thus VAW.

Examples of intervention: Teaching relationship skills.

Enhancing the social and economic empowerment of women and girls: Interventions that improve women and girls' social and economic empowerment are important to protect them from victimisation and to support themselves should they want to leave a violent relationship.

Examples of intervention: IMAGE and Stepping Stones interventions; developing opportunities for women to access tertiary education.

Strengthening formal and informal legal, health and social support structures: This is important to increase the social and legal accountability for violence and reduce the impact of VAW. Even though only a small proportion of men who rape are reported to the police, vigorously pursuing these cases can send an important message that rape cannot be perpetrated with impunity. This is also important for stopping patterns of repeat offences, which is particular notable in both rape and IPV.

Examples of intervention: Psychosocial services for victims of IPV and SV.

Strengthening health services, especially mental health services: Mental health services are vital for treating depression as a risk factor for VAW. These services also help reduce the trauma-induced risks that result in women who have experienced VAW, especially rape, remaining at heightened risk of repeated victimisation.

Examples of intervention: Accessible primary mental health care, including cognitive behavioural therapy (CBT) for victims of trauma.

What could be done to ensure more effective implementation of VAW programmes in South Africa?

- **Scale-up proven good practices that have been tested in South Africa:** e.g. microfinance for women and empowerment training;

- **Improve monitoring and evaluation**
  - ***Conduct external rigorous evaluation of governments' and CSOs programmes,*** which would enable these to be strengthened and clarify their effectiveness. These evaluations could also describe the comparative advantages of each government department and CSOs in conducting various types of interventions in order to avoid duplication;
  - Develop time-bound **action plans** with clear roles and responsibilities and accountability mechanisms on each programme;
  - Link the various programmes' M&E frameworks and coordination forums;
- **Increase funding for VAW prevention and response:**
  - Analyse the cost of VAW in South Africa;
  - Analyse resource allocation on both response and prevention;
  - Develop a VAW prevention budget and realistically fund prevention and response to VAW.
- **Improve existing government programmes**
  - **Develop norms and standards**
    - For the training for all government officials as well as evaluation guidelines that would test the quality and effectiveness of the training;
    - For the one stop centres, and rationalize them based on the comparative advantage of the departments;
    - For the shelters
  - **Shelters:** increase funding and develop funding guidelines, strengthen and widen the scope of the economic empowerment opportunities offered to women and make provisions for children;
- **Improve the legal framework**
  - **White Paper on Families:** Revise the paper to better consider the need to strengthen proven initiatives aimed at women's empowerment and at changing norms;
  - Finalise the amendment of the DVA

  - Revise governance mechanisms
  - Legislate on the role of DoH and DSD, as well as DBE
  - Cost the DVA
- Define domestic violence as a criminal offence in its own right and mandate annual reporting of the number of police cases of domestic violence against women by male intimate partners and number of protection orders applied for and finalised for this category of domestic violence.

How can we promote social and behaviour change in relation to positive norms around VAW?

Given the scale of VAW in South Africa, there is clearly a need for well-designed robust communication programmes on VAW aiming at changing the social norms on gender. Some considerations for designing and implementing an SBCC programme include:

- Development of a clearly articulated theory of change as to how exposure to the campaign aims to impact on intermediary factors and behaviour;
- Formation of a multi-disciplinary and cross-sectoral steering committee to guide the strategic direction and effective implementation of the campaign;
- Conducting formative research to clearly identify the target audience(s), key messages and approach to be used;
- Ensuring a national campaign that goes beyond addressing the individual, but also aims to impact at multiple mutually reinforcing levels including individual, community and socio-political environment;
- Ongoing monitoring and rigorous evaluation, which addresses attribution and is based on the theory of change.

Coordination: How to increase unity of purpose, synergy, effectiveness and impact? What needs to be in place to ensure a unified, coordinated and sustainable multi-sectoral approach to VAW?

The GBV Council is still in its infancy and has yet to put in place the various governance mechanisms required to start functioning fully. The announcement that the IMC would merge with the GBV Council and the as yet unclear role of civil society in the Council indicates the need to reconceptualise governance structures and accountability mechanisms. In the light of duplication, service delivery and budget challenges, it seems that the main function of the GBV Council should be to ensure accountability, avoid duplication and allow for a scaling up of good practices. It should also improve collaboration between CSOs and government departments, and in particular use the technical expertise of civil society, including the research sector, in the development of programmes and policies that govern the services they implement.

Based on the above, the following recommendations can be made:

- Restore confidence and interest of all stakeholders (CSO, research sector and government departments) in a multi-sectoral approach;
- Clarify the mechanisms of governance of the GBV Council and communicate them to all stakeholders, taking into consideration the merger with the IMC;

- Clarify and communicate who will ensure the overall accountability of the implementation of the over-arching plan and how;
- Clarify the functions of the GBV Council, taking into consideration the comparative advantages of each government department and CSOs;
- If the SANAC (South African National Aids Council) model is to be followed:
    - It is important to learn from SANAC and avoid repeating mistakes in the design of the governance mechanisms;
    - The GBV Council could be chaired by a senior political representative who has a very high level of political and institutional authority, such as the Deputy President;
    - CSOs could have a role in developing and monitoring the plan.

Further recommendations on coordination

- Rationalize coordination at all levels;
- Strengthen donor coordination to avoid duplication;
- Develop a national integrated M&E system on VAW, based on existing indicators collected and develop a monitoring tool;
- Centralize administrative data and research on VAW.

Which areas need further research?

This report showed that reliable data informing on the scale of the IPV and SV epidemic in the general population exist in South Africa, even though there is no rigorous mechanism for population-based surveillance of VAW. It also showed that the response does not match the scale of the epidemic and is not sufficiently informed by research. More emphasis should also be placed on primary prevention of VAW. Based on these gaps, further research is needed on the following areas:

Include questions on violence against women in the next Demographic and Health Survey

- The next South Africa Demographic and Health Survey can provide a good platform for gathering data on violence against women, providing that data collection methods are guided by international ethical and safety guidelines. It is hoped that this survey will be implemented in 2015.

Research to monitor the response

- National coverage of interventions (looking at their scope, population reach and geographical coverage);
- Trends in key indicators of the VAW response, such as number of health professionals trained in post-rape care or on VAW.

Research on primary prevention intervention, response evaluation and scale up

- Develop and test the effectiveness of IPV/SV primary prevention interventions – particularly school based and parenting interventions;
- Evaluate existing interventions that seek to prevent sexual violence;

- Conduct systematic rigorous localised baseline/situational analysis to tailor interventions to local needs and realities;
- Conduct research on how to scale up the interventions that work;
- Conduct research on the costs of preventing VAW and the impact of scale up on costs and effectiveness; and
- Conduct research to develop and test interventions for vulnerable groups

What should be done to improve VAW data collection and analysis?

Surveillance and monitoring of trends

- A national surveillance system for VAW needs to be established and resourced so that the impact of interventions on the general population can be measured and monitored over time. The system must prioritise quality assurance and draw on locally and international good practice, recognizing the methodological and ethical difficulties of research in this field;
- A key indicator list that should be measured and monitored should be developed and must include:
    - Past year prevalence of physical, sexual and emotional IPV, non-partner sexual violence, including injury, reporting to police and accessing counselling;
    - Intimate femicide and rape homicide;
    - Reports to SAPS of rape matters;
    - Case attrition in the criminal justice system;
    - Trends in IPV and rape perpetration risk factors;
    - Trends in prevalence of vulnerable groups including lesbians and women with disabilities.

Annexure 1

List of interview respondents

	Interviewees	Organisation	Designation
1.	Ms Tsholo Moloi	Department of Social Development	Director: Victim Empowerment Programme
2.	Adv. PM Kambula	Department of Justice and Constitutional Development	Chief Director: Promotion of the Rights of Vulnerable Groups
3.	Ms Veliswa Baduza	Department of Women, Children & People with Disabilities	Director General
4.	Ms Ranji Reddy	Department of Women, Children & People with Disabilities	Chief Director, M&E; Women's Empowerment and Gender Equality Branch
5.	Ms Dikeledi Moema	Department of Women, Children & People with Disabilities	Chief Director; Secretariat for the National GBV Council
6.	Dr Mannah	Department of Basic Education	Acting Chief director for Social Inclusion and Partnerships in Education
7.	Ms Pumeza Mafani	National Prosecuting Authority	National Coordinator for the Thuthuzela Care Centres; Sexual offences and Community Affairs Unit
8.	Mrs Pakiso Martha Netsidsvhani	Department of Health	Chief Director for Violence, Trauma and Emergency Medical Services and Forensic Services; tertiary health Services Branch
9	Ms Tamara Braam	Joint Gender Fund	Independent Consultant
10	Mr Zane Dangor	Department of Social Development	Advisor to the DSD Minister
11.	Mr Paul Jansen	HIVOS	Director
12.	Mrs Sisonke Msimang	Sonke Gender Justice Network	Sonke
13	Ms Hilary Nkulu	Irish Aid	Irish Aid

Research Experts Reference Group

	Name	Organisation
1	Ms Shanaaz Mathews	UCT Children's Institute
2	Ms Naeema Abrahams	Medical Research Council
3	Ms Lisa Vetten	Independent Researcher
4	Dr Mzikazi Nduna	Wits University
5	Ms Elizabeth Dartnall	Medical Research Council
6	Ms Zosa De Sas Kropiwnicki	Wits University
7	Ms Joy Watson	Parliament of South Africa Research Unit Socially Vulnerable Groups & Members' Legislative Proposals Cluster
Senior Technical Advisor and Reviewer		
	Prof. Rachel Jewkes	Medical Research Council

Annexure 2

Civil Society Questionnaire

Civil Society Response mapping questions

Name of the organisation: _____

Name of your VAW programme (1)[195] : _____

Programme activities (i.e. campaigns, training, support to access health services, legal support, etc…)	Number of districts (if not a provincial level activity)	Number of communities (for sub-district programmes)	Number of beneficiaries per annum (for targeted interventions or services) – indicate the year (use most recent) report
1.			
2.			
3.			
Etc…			

Has/have your programme(s) ever been evaluated (or some activities of your programme(s))?

If yes, can you share with us a summary of the main findings and possibly send us the evaluation(s)?[196]

[195] If your organisation has several programmes, please cut and paste the table several times

[196] Please note that the aim of this question is to assess how many VAW programmes or programme activities were evaluated as a whole in South Africa, and if some practices are identified as good practices – it is not to produce any judgment on your programme.

Can you tell us the budget of your VAW programme(s)?[197]

Do you have any questions or additional information you wish to share with us?

Annexure 3

SBCC programme evaluation case study

Case study: Impact evaluation of Soul City's Fourth Series on Violence against Women

Background:

The Soul City Institute for Health and Development Communication together with the National Network on Violence Against Women (NNVAW) formulated an intervention to address domestic violence. Recognising that behaviour change interventions aimed solely at individuals have limited impact, the intervention was designed to impact at multiple mutually reinforcing levels: individual, community and socio-political environment.

Intervention:

Soul City consists of prime time radio and television dramas and print material. It uses edutainment, where social issues are integrated into entertainment formats, which has been shown to be a powerful mechanism to achieve social change objectives. Through drama, Soul City is able to reach prime time audiences, and through radio particularly, reach marginalized, rural communities. Domestic violence was a major focus of the fourth series of Soul City (SC4).

Objectives and approach:

Level of change	Objectives	Approaches
Societal	Increase public debate in the national media	An advocacy campaign was conducted to ensure the implementation of the DVA. The DVA featured in all the SC4 materials. Media advocacy and social mobilization were used to gain public support and reach decision makers. A resource pack for journalists was produced and workshops were held to familiarize journalists with the issues.
	Advocate for the speedy implementation of the DVA	
Interpersonal and community	Promote interpersonal and community dialogue	SC4 mass media, pamphlets, posters and community events. Community action was built into the narrative of the drama with the aim of enhancing collective efficacy
	Promote community action	
	Shift social norms	

[197] Please note that the aim of this question is to assess the total amount spent in South Africa on VAW programmes.

Individual	Shift attitudes, awareness, knowledge, intentions and practice	The partnership established a toll-free helpline to support audiences. The helpline was role-modelled in the drama and advertised in all SC4 materials
	Enhance self-efficacy	
	Increase supportive behaviours	
	Connect people to support services	

Evaluation methods:

In order to evaluate impact at the three levels listed above, the evaluation was multifaceted, consisting of six interrelated studies, triangulated to investigate consistency of findings and improve validity of the results. These included:

(1) A nationally representative quantitative survey: baseline (pre-intervention) and evaluation (post-intervention). Data was collected using a multi-stage stratified national random sampling study design. Standardized, face-to-face interviews were conducted with a comparable sample of 2,000 adults aged 16–65 in each survey.

(2) A national qualitative impact assessment: 29 focus group interviews and 32 in-depth interviews were conducted among SC4's target audience and community members representing leadership, services and civil society.

(3) Evaluation of the partnership between SC4 and NNVAW: data collection consisted of 97 semi-structured interviews and focus group interviews with government; service providers; NGOs; journalists; training institutions; community members; intervention partners and stakeholders; and external observers of the DVA policy process. The study further monitored the national print and electronic media over a six-month period, and monitored helpline calls over a five-month period using records obtained from the telecommunications service provider.

Results:

The intervention and its evaluation results are presented. Soul City successfully reached 86%, 25% and 65% of audiences through television, print booklets and radio respectively. On an individual level there was a shift in knowledge around domestic violence, including 41% of respondents hearing about the helpline. Attitude shifts were also associated with the intervention, with a 10% increase in respondents disagreeing that domestic violence was a private affair. There was also a 22% shift in perceptions of social norms on this issue.

Qualitative data analysis suggested the intervention played a role in enhancing women's and communities' sense of efficacy, enabling women to make more effective decisions around their health and facilitating community action. The evaluation concluded that implementation of the DVA can largely be attributed to the intervention. While demonstrating actual reductions in levels of domestic violence was not possible, the evaluation shows a strong association between exposure to intervention components and a range of intermediary factors indicative of, and necessary to, bringing about social change.

Conclusions:

The SC4 evaluation pointed to the value of a partnership model combining the social mobilizing capabilities of organisations on the ground with the clout of large scale mass media interventions. This, together with the success of the advocacy campaign, resulted in the formalization of partner social mobilization and advocacy strategies into the organisation's work. The strategy of edutainment was also shown to be an important mechanism for social change. Despite its limitations, the evaluation demonstrated that the intervention successfully impacted on social change at three levels—individual, community and socio-political, pointing to the value of an ecological approach when planning social change interventions.

Source: S.Usdin, E. Scheepers, Susan Goldstein, Garth Japhet. (2005) Achieving social change on gender-based violence: A report on the impact evaluation of Soul City's fourth series. *Social Science & Medicine 61*: 2434–2445

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