CHAPTER 6
Response to GBV

Activists demand a response to GBV. *Photo: Colleen Lowe Morna*

Key facts

- ✓ South Africa is party to international and regional commitments which aim to end discrimination against women.
- ✓ South Africa has progressive GBV legislation: the Domestic Violence Act (DVA) and Sexual Offences Act (SOA).
- ✓ 77.2% of men and 73.9% of women are aware of the DVA.
- ✓ 55.8% of men and 36.3% of women are aware of the SOA.
- ✓ 22 Family Violence, Child Protection and Sexual Offences Units have been re-established in Gauteng police stations.
- ✓ 122 victim empowerment centres operating in Gauteng police stations.
- ✓ Only 9.8% of police stations audited are fully compliant with the DVA.
- ✓ 50 611 applications for domestic orders were made in Gauteng in 2009-2010.
- ✓ 30.2% of all Gauteng domestic violence cases were finalised.
- ✓ 18 022 sexual offence cases were outstanding as of 31 December 2009.
- ✓ 1% of politicians' speeches refer to financial resources for addressing GBV.
- ✓ Only 3 198 of the 4 386 adults who presented themselves within 72 hours of the incident in Gauteng were eligible for PEP. However, just 2 698 adults (or 61%) received PEP.
- ✓ Thuthuzela Care Centres linked to Sexual Offences Courts provide the most effective services to survivors of sexual assault but there are insufficient to meet the need.

Mamokhutu Santho, "I" Stories participant 2006. *Photo: Colleen Lowe Morna*

What does justice mean, when I, the survivor am victimised even more; when every system seems to work to the benefit of the perpetrator? I have been to every court. I have canvassed minis-ters, deputy ministers and even the Deputy President. I am breaking my silence because it is time we, as women, put the facts as they are: the legal system is not working for us.

At the beginning, I was madly and uncondi-tionally in love with this man. He was seven years my senior, which made me feel secure. I believed he was mature and would take good care of me. He convinced me that we were meant for each other. On 18 July 1992 we tied the knot. We lived happily for the first few months. But in April 1993, six months after I gave birth to our first child and nine months after our wedding, my husband's behaviour began to change. This marked the beginning of what would become a way of life for me with this man. There were many incidents.

I documented all the abuse I suffered, like on 24 May 1997 after we moved into our new house. He accused me of playing loud music. I protested and he beat me up with a knobkerrie until it broke into two pieces. After this he forcefully made love to me. Three days later I contacted an NGO that provides counselling. I went to the Bloemfontein magistrate court to apply for a court interdict. This infuriated him and marked another turning point in our relationship. My life became more miserable.

On a fateful day in November 1997 we had another fight after he came home past two o'clock in the morning. When he got home he tried to force himself onto me and I resisted. I needed him to explain where he had been all night. He beat me and threatened to kill me. I managed to free myself and escaped from our bedroom into the children's bedroom, broke their window and jumped through. I was stark naked with no panty, bra, shoes, nothing. Blood was oozing all over my body. I ran to the neighbour's house. I went to report him to the police and he was arrested at his Nedbank offices. He appeared in court and was released on bail of R1 500. That was supposed to compensate for the pain and misery.

I filed for a divorce in February 1998 and moved to Johannesburg after I had received advice from a psychologist who ironically had been asked by my husband to assess whether I had a mental illness. My husband was in denial. Ironically, the court granted my husband custody of the children, despite the fact that the earlier psycho-logist had concluded that he was the one with a problem and not me. I, on the other hand, was granted "reason-able access" to the children.

Meanwhile I had filed assault cases against my husband. To my horror, all the lodged dockets went missing at the magistrate's court. I believe that my husband used connections to hide all the vital information: court book, charge sheet, tapes, and dockets. The documents were eventually found and my husband was fined a mere R4 000, compared to the R20 000 I spent in my quest for justice. What justice! In January 2001, I filed for damages under civil claims in the same court. In February 2003, I received R17 000 as a settlement.

This story by Mamokhothu Santho is an example of the challenges abuse survivors face in their quest for justice. Santho was physically and emotionally abused by the man she loved. He regularly beat her and even threatened to kill her. When she finally got through to court, the ruling was not in her favour. She was deemed emotionally unstable and lost custody of her two sons. Such an experience left her to ask the critical question about whether justice will ever be served.

This chapter explores political commitments and the services in place to respond to women who are survivors of GBV. These include the multi-sector response to GBV by health and social services actors, legislative, police, civil society and the community. The chapter also evaluates the quality of services, whether they are used by survivors and whether they effectively meet the needs of survivors.

Political commitment to addressing GBV

One of the indicators to measure political commitment to end GBV is the ratification and adoption of legal instruments and the existence of institutional mechanisms which facilitate the elimination of GBV. South Africa is signatory to several conventions to combat gender-based violence, including the Convention on the Elimination of Discrimination against Women (CEDAW), the Beijing Platform for Action (BPA); and the Protocol to the African Charter on Human and Peoples Rights on the Rights of Women in Africa.

Table 6.1 South Africa's progress against different instruments

Instrument	State responsibility	Progress made
CEDAW	1. Provide support services for all survivors of gender based violence, including refuges, specially trained health workers, rehabilitation and counselling services.[46]	1. Mechanisms have been established to address the needs of survivors, including one-stop centres with counsellors, police and legal officers.
	2. Use "due diligence" to prevent, prosecute and punish perpetrators who commit violence against women.	2. A 365 day National Action Plan is in place to address GBV.
	3. Collect data on violence against women.	3. A progressive legal framework that ensures the protection of women rights is in place.
	4. Sensitise members of the criminal justice system.	4. Police and prosecutors are being trained to address issues of sexual violence.

[46] Commission on Human Rights, 1996.

Instrument	State responsibility	Progress made
Beijing Declaration and Platform for Action (1995)	1. Enact legislation on preventing and addressing issues of violence against women and girls.	a) Domestic Violence Act, 1998 (Act 116 of 1998); b) Sexual Offences Act, 1957 (Act 23 of 1957); c) Criminal Law(Sexual Offence and related Matters)Amended Act,2007(Act 32 of 2007); d) Employment Equity (Act No 55 of 1998).
	2. Put in place strategies to address survivors of violence, as well as strategies with punitive measures against perpetrators of violence against women.	a) The Anti-Rape Strategy (prevention, reaction and support) developed by inter-departmental Management Team as an integrated response on violence against women; b) Domestic Violence Programme (prevention and reaction); c) Child Abuse and Neglect programme (prevention and reaction); d) Inter-departmental initiatives to improve Criminal Justice System processes for Rape and Sexual Offences (e.g. Multi-Disciplinary Service Centres, specialised training, Sexual Offences Courts, FCS Units); e) Communication, Education and Awareness programmes; f) Local and community-based programmes (community policing, neighbourhood watches).
SADC Gender and Development Protocol in 2008	1. Enacting and enforcing prohibitive legislation	a) Domestic Violence Act, 1998 (Act 116 of 1998); b) Sexual Offences Act, 1957 (Act 23 of 1957); c) Criminal Law(Sexual Offence and related Matters)Amended Act,2007(Act 32 of 2007) d) Employment Equity (Act No 55 of 1998)
	2. Eradicating social, economic, cultural and political practices and religious beliefs that legitimise and exacerbate the persistence and tolerance of GBV.	Communication, Education and Awareness programmes commissioned
	3. Adopting integrated approaches, including institutional cross-sector structures, with the aim of reducing current levels of violence by 50%.	Inter-Departmental Management Team (IDMT) put in place at government level to coordinate an integrated response to violence against women.
	4. Ensure implementation, monitoring and evaluation of these above mentioned efforts.	Although systems have been put in place there is need for more vigilant data collection and management. There is need for comprehensive set of indicators to evaluate progress. In conducting this research GL is testing a set of indicators which can be used as baseline and to monitor GBV programmes.

National legal framework

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

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

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

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

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

The Employment Equity (Act No 55 of 1998) was formulated to protect women from abuse in the workplace. This legislation recognises sexual harassment in the workplace as a form of unfair discrimination against employees.

Public awareness of national legislation

Participants in the prevalence and attitudes survey were asked whether they knew about the DVA and SOA. Results show that although the basic legislation frameworks are in place, much has to be done at government level to publicise GBV legislation.

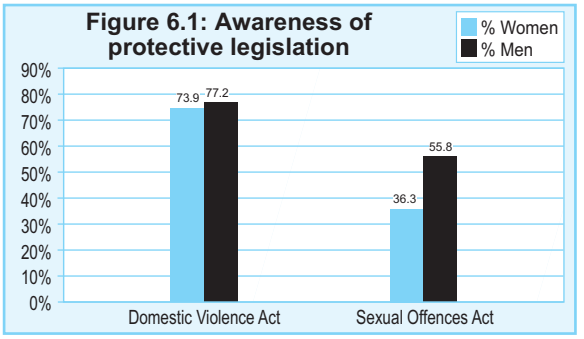


Figure 6.1 shows that two years since its enactment, only 36.3% of women and 55.8% of men had heard of the SOA. This reflects the need for government to put more effort into publicising new legislation. Although participants had greater knowledge of the older DVA, about one in four (26%) women and 22.8% men said they had never heard of the DVA.

Political discourse on GBV

Politicians' speeches about, or against, GBV have the potential to create greater public awareness and present the fight to end GBV as a public priority. Politicians' consistent condemnation of GBV during their public addresses shows clear commitment to ending the problem. Politicians' discourse about GBV can positively impact on the way citizens' access knowledge and shape their opinions on GBV. As explained in the methodology, this study analysed the extent to which GBV is mentioned in 1956 official speeches delivered by politicians at both national and provincial national during the period April 2009 to March 2010. GBV was only referred to either directly or in passing in 4% of these cases. GBV is most mentioned by politicians during higher level government platforms such as during budget votes and in parliament. One in eight (12.6%) of speeches that mentioned GBV were made during a departmental budget vote while 10.3% of speeches were made in parliamentary debate. GBV is also mentioned at the opening of parliament and at presentations of relevant bills.

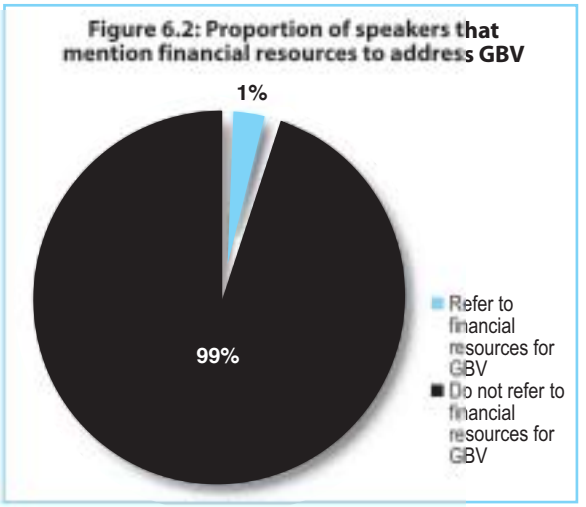


Figure 6.2 shows that just 1% of speeches made reference to financial commitments to addressing GBV, making it difficult to ascertain institutional costs around addressing this problem. Cabinet ministers made the most reference to any commitment to ending GBV in 34.5% of speeches, followed by cabinet deputy ministers at 15.5%, party functionaries and shadow Ministers both at 12.1%, Provincial MECs at 8.6%, and Members of Parliament at 3.5%. It is worth noting that speeches by President Jacob Zuma only accounted for 1.7% of those mentioning financial commitment to ending GBV, fewer than Deputy President Motlanthe (5.2%).

In her 2010 State of the Province address, Gauteng Premier Nomvula Mokonyane pledged

to continue to roll-out localised survivor support services, making them more accessible to women and children in need. She also alluded to providing and ensuring the effective functioning of the 134 survivor empowerment centres across the province.[47]

Public services

There has been some progress at a department level and among Civil Society Organisations (CSOs) in providing services to survivors of GBV. Most government departments have been oriented towards response and support while the thrust by CSOs has been support and prevention campaigns. Whenever survivors access these services, client data is collected as a routine exercise. The study obtained data in this chapter on access to services from liaising with respective departments and organisations. In instances where service providers did not make information readily available, the research made use of past annual reports and information from organisational websites.

South African Police Services

The DVA states that it is the responsibility of any member of the South African Police Service to present him or herself at the scene of an incident of domestic violence in as little time as is reasonably possible or when the incident of domestic violence is reported. They should then render such assistance to the complainant as may be required in the circumstances. This includes assisting or making arrangements for the complainant to find a suitable shelter and obtain medical treatment if necessary.

Specialised units within SAPS

In order to better respond to GBV, SAPS has created specialised units whose sole responsibly is to address issues of domestic violence at police station level.

Family Violence, Child Protection and Sexual Offences Unit (FCS)

FCS is a unit within the SAPS. FCS units police crimes of domestic violence, sexual offences and child protection. Established in 1995, this police department disbanded in 2001 but is currently being re-established. In Gauteng, 22 units have been re-established and 58% of officers commanding the units are women.[48]

SAPS plays a big role in responding to GBV. *Photo: Colleen Lowe Morna*

[47] http://www.gep.co.za/?module=menu&sub_module=display_content&id=28 State of the Province Address by Gauteng Premier Nomvula Mokonyane, Gauteng Legislature, Johannesburg 22 February 2010.
[48] GSAPS 2011.

Victim Empowerment Centres (VECs)

Another SAPS achievement has been the introduction of survivor empowerment centres (VEC) within police stations as part of the integrated response within the provincial Victim Empowerment Programme (VEP). To date, 122 VECs have been established and are operational at police stations around the province. The main function of VECs is to support and refer survivors, if necessary, to Ikhaya Lethemba (IKLT), a departmental one-stop centre, or to other service providers. Three Regional Victim Offices (RVOs) have also been established in Gauteng. These RVOs offer various survivor support and empowerment services, including social workers at police station level.[49]

Female SAPS: more empathy towards GBV survivors? *Photo: Trevor Davies*

From December 2009 to April 2010 the Gauteng Department of Community Safety conducted a baseline Victim Satisfaction and Empowerment study[50] among all survivors that stayed at IKLT or accessed VECs/RVOs since 2006.

The study used both qualitative and quantitative research methodology and attempted to determine if survivors were satisfied with the services. Clients commended the VECs, noting they made good referrals to hospital, courts, shelters and IKLT. The officers at VECs were said to be supportive, empathetic, respectful, caring, and attentive to survivors' problems. Clients also appreciated the reception, staff attitude, food, legal assistance, follow-up and safety and security.

However, some respondents reported dissatisfaction because there was no follow-up; staff shortages; biased policemen who were empathetic with GBV perpetrators; no counselling offered; lack of vehicles; and, in some instances, absence of staff. Some clients said they did not trust the officers and felt they were not transparent.

Recommendations made by survivors include hiring more staff, training staff on GBV and infrastructural changes to allow confidentiality when reporting a case. Police officers were encouraged to listen to survivors and take all cases seriously, not judge survivors and be consistent with follow-ups.

[49] GDCS, 2010.
[50] Gauteng Department of Community Safety Baseline Survivor Satisfaction and Empowerment study 2010.

Non-compliance with DVA

Reports to Parliament by the Independent Complaints Directorate (ICD) reflect numerous instances of non-compliance with the DVA. These include complaints received and the results of police station audits. The IDC received 123 complaints about the failure of SAPS members to comply with the DVA between January and December 2009. Most cases were from Gauteng and 32% of cases arose from failure of SAPS to arrest the abuser. Another 18% of cases pertained to failure of a SAPS officer to arrest the alleged transgressor on receipt of a warrant issued by court or an affidavit that a Protection Order had been violated.

Figure 6.3: Compliance of audited police stations to requirements of the DVA

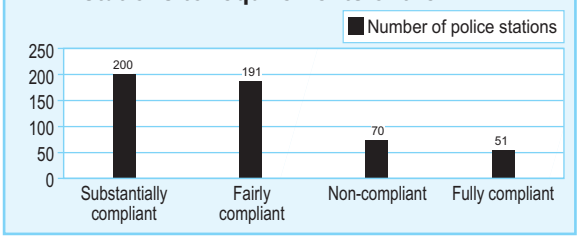


Figure 6.3 shows that of the 1116 stations nationwide, only 51 (9.8%) of audited police stations were fully compliant with the DVA while 70 (13.4%) were non-compliant. The 391 remaining stations (74.9%) were compliant to varying degrees.[51]

Some of the reasons for non-compliance included: officers did not understand the DVA and the obligations imposed by it; copies of the DVA and National Regulations were not available as required; and police leaders took too long to discipline SAPS members. Record-keeping was another common reason for non-compliance, as was failure to notify the ICD of non-compliance and a culture of silence around domestic violence.[52]

Failure to arrest perpetrators

Poor police information and evidence collection contributes to low rates of arrest and prosecution of perpetrators (Tracking Justice Report). Experiences of survivors within the justice system were explored through analysing their stories.

Let down by the system

A stark finding is that survivors of GBV often feel the system has let them down, as evident in the excerpt from Nono Tintela's story:

"I am angry at our justice system for not protecting women and children. I am angry at our courts for releasing these monsters back to

Nono Tintela, a survivor. *Photo: Colleen Lowe Morna*

[51] ICD, 2010.
[52] ICD 2010.

our homes. I am angry at the man who raped me as a child and now walks the streets as a respected politician. I am angry at the man who made me pregnant and then walked away, leaving me so angry towards my first daughter (now 20-years-old) with whom I have never been able to have a bond. I am angry at all men for treating us like doormats. I am angry at my father for not protecting me. Worst of all I am angry at me for not protecting my second daughter when the very same thing that happened to me happened to her."- From the "I" Story *I am angry, but I am also a survivor* by Nono Tintela

Proudia Mosupi. *Photo: Colleen Lowe Morna*

Proudia Mosupi similarly wrote:

"I am getting very little cooperation from the police, who fail to understand how you can be raped by someone you know. Even though my rapist is well known, he has not been apprehended." - From the "I" Story *One man's love eases the pain of another's assault* by Proudia Mosupi

Gaps in SAPS DV data

In 2008, the SAPS responded to demands by civil society to differentiate between reported cases of domestic violence and other cases. This resulted in the SAPS adopting a policy of categorising those reported domestic violence-related cases separately. This would enable police to provide reliable administrative data distinguishing domestic violence across all reported crimes.

However, analysis of the SAPS dataset of all crimes committed in Gauteng coded as "domestic violence" for the period 2008 to 2009 proved problematic. In South African law there are a range of offences which can be labelled "domestic violence". These include common assault, assault with the intent to do grievous bodily harm, contravention of a protection order, murder, *crimen injuria* (unlawfully, intentionally and seriously impairing the dignity of another), sexual offence, abduction, indecent assault, rape of wife by own husband, compelled rape, pornography and sex work.

This categorisation potentially poses important limitations. It is unclear what circumstances led data capturers to use the "domestic violence" variable and this will have varied from station to station. No data on the relationship between the perpetrator and the survivor is available. This means that crimes occurring in a domestic setting, such as an adult male child abusing an elderly male parent, could have been captured as "domestic violence". This affects the validity of results and as such they should be interpreted with some caution. It is also unclear whether an episode of violence perpetrated against an intimate partner outside the home would have consistently been captured using the "domestic violence" code.

Murder is another category under the Domestic Violence Act, making it difficult to ascertain which female murders are intimate femicide. There is a need for SAPS to capture data on the relationship between the perpetrator and the survivor if this information is to be obtained. Previous research on SAPS murder dockets indicates that it is possible to ascertain the circumstances surrounding murder. Routine inclusion of this information when capturing data will go a long way toward providing initimate femicide statistics.

Conflation of sexual offences in police reports, including pornography and sex work, as aforementioned, masks the true statistics of violence occurring in the home, as well as exact rape statistics. Because of this it is unclear whether there is an increase or decrease in the actual extent of sexual offences as reported by police or whether more or less people have been charged for running brothels or soliciting sex. It is imperative that the domain where offences take place is confined to the "public" or "private/home" as elucidated in the Declaration on the Elimination of Violence against Women. The domestic violence category is not reported separately in annual police reports and this requires attention given these survey findings.

Case backlogs, poor conviction and high withdrawal rates

According to the annual 2010 Department of Justice and Constitutional Development (DOJCD) for the year 2009 to 2010, a total of 18 022 adult sexual offences cases were still outstanding nationally on 31 December 2009.[53]

Table 6.2: Outstanding adult sexual offences cases according to enrolment year (31 December 2009)

	2006	2007	2008	2009	Total
Number of cases	311	1 120	3 431	13 160	18 022

Table 6.2 shows that 27% of outstanding sexual offences cases were enrolled before 2009 and are more than a year old. This finding underscores the issue of considerable sexual offences case backlogs within the justice system.

Even within specialised sexual offences courts, the conviction rate for sexual offences was found to be 72.8%.[54] The failure to convict or administer justice, coupled with possibility of secondary victimisation, may act as a deterrent to the reporting of violence.

Judge Yvonne Mokgoro. *Photo: Gender Links*

[53] http://www.justice.gov.za/reportfiles/anr200910/anr2009_2010_part2.pdf
[54] Ibid.

Table 6.3: National and Gauteng provincial domestic violence cases for period 2009-2010						
	Old applications (before April 2009)	New applications (from April 2009)	Total applications	Orders granted	Finalised cases	Withdrawn cases
National Domestic violence statistics for 2009/2010	66 314	225 232	291 546	141 159	77 178	49 360
Gauteng Domestic violence statistics for 2009/2010	10 646	39 965	50 611	29 435	15 269	10 708

Table 6.3 illustrates that many cases of domestic violence are reported both at national and provincial level. More than half (58.2%) were granted a protection order. Also apparent are the high withdrawal rates of domestic violence cases. Almost one in every five cases (21.2%) get withdrawn from the system.

Health sector

Public health approaches are critical in responding to, and addressing, GBV.

National Management Guidelines for Sexual Assault Care

Women who have been raped have particular health needs which include supporting their mental health; preventing pregnancy, HIV, and other sexually transmitted infections; and the management and documentation of injuries.[55] The *National Management Guidelines for Sexual Assault Care* (National Guidelines) developed by the South African National Department of Health (DOH) in 2004 are a notable achievement of the health care sector in responding to GBV. The National Guidelines include both general health standards for sexual assault management as well as specific standards relating to medical-legal examination and documentation, psychological support, reproductive health, and HIV. HIV-related standards include voluntary testing and counselling, provision of PEP, follow-up HIV testing and referral of HIV positive patients for further HIV management as shown in the excerpt from the SOA.[56] There is also a National Curriculum to train health professionals in post-rape care.

Rape survivors should go to a health facility within 72 hours of the assault to access PEP.
Photo: Gender Links

[55] N J Christofides, D Muirhead, R K Jewkes, L Penn-Kekana, and D N Conco.2006. Women's experiences of and preferences for services after rape in South Africa: interview study BMJ. 2006 January 28; 332(7535): 209-213.
[56] Republic of South Africa National Sexual Offences Act.

Legislative provisions for health care after sexual assault

"(1) Where a person has sustained physical, psychological or other injuries as the result of an alleged sexual offence, such person shall, immediately after the alleged offence, receive appropriate medical care, treatment and counselling as may be required for such injuries.

(2) If a person has been exposed to the risk of being infected by a sexually transmissible infection as the result of a sexual offence, such person shall, immediately after the reporting of the alleged offence to the South African Police Services or to a health care facility -

(a) be advised by a medical practitioner or a qualified health care professional of the possibility of being tested for such infection; and

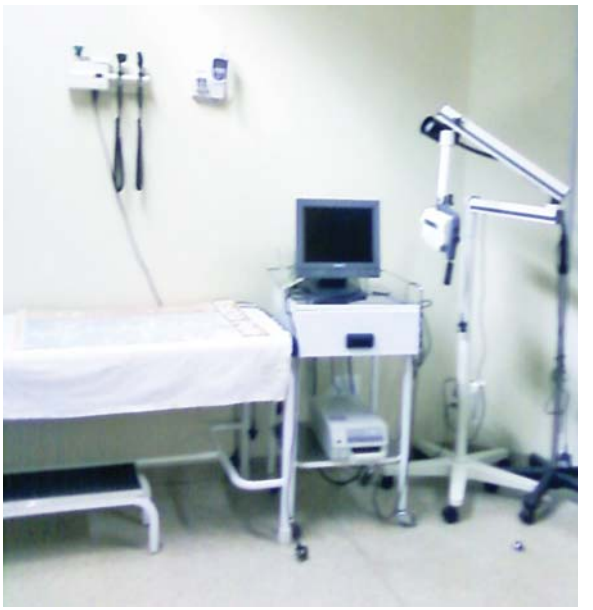
(b) have access to all possible means of prevention, treatment and medical care in respect of possible exposure to a sexually transmissible infection.

(c) The State shall bear the cost of the care, treatment, testing, prevention and counselling..."

Access to health services by rape survivors

Sexual assault services are provided nationally by a wide range of health service providers including Thuthuzela Care Centres (TCCs) or one stop services; NGO-run centres, and crisis centre units within public hospitals and community health centres. Sexual assault management is part of the overall health service package coordinated through district health services, and may also be provided by private doctors, clinics and hospitals. Most service providers are not able to offer a full-range of services, however, and links between health and the justice system are generally not well established outside the TCCs.

In 2009, Gauteng public health services report attending to 4906 adult rape survivors; SAPS statistics for April 2009 to March 2010 reflect 15 645 sexual offences reported to police, and the prevalence survey suggests that the number may have been considerably higher. Some health facilities had missing data for certain months in this time period which means that this number is an underestimation of survivors seen at health facilities. Still it seems likely that many survivors who experience and or report rape do not access public health services.



Medico-legal clinic room at IKLT. *Photo: Gender Links*

Of the reported cases, 4776 (97.4%) were offered HIV tests at public health facilities and more than a quarter (28.1%) were HIV positive. These survivors were therefore not eligible for Post Exposure Prophylaxis (PEP). Only 3198 of the 4386 adults who presented themselves within 72 hours of the incident were eligible for PEP. However, just 2698 adults (or 61%) received PEP. Some patients are not given the full 28-day PEP pack after the starter pack, which is a deviation from national and international guidelines. The findings do, however, show that all clinics provide Voluntary Counselling and Testing (VCT) for HIV.

Health personnel attitude

The National Guidelines provide an implementation framework to improve the quality of health care provided to sexual assault patients across South Africa and to reduce the secondary trauma commonly associated with the process of seeking sexual assault care. Some services in Gauteng and other provinces have been established and run by extremely caring and dedicated health professionals. Yet in other cases, despite the commendable operational framework, attitudes and capability of health workers remains poor.

Secondary victimisation

Keba Seboatane. *Photo: Colleen Lowe Morna*

Survivors of violence, among them lesbians, may face secondary traumatisation resulting from discriminatory attitudes of service providers as illustrated Keba Seboatane's "I" Story:

"I told him [the doctor] that the guy raped me because I was a lesbian. As soon as he heard this he stopped writing and posed questions regarding my sexuality. He said: 'Why are you a lesbian at this age? Do you know that it is against the constitution to make such a decision without the consent of a parent? You are wearing a cross of Christ, did you know that it is an abomination in the eyes of God to be lesbian.'"- From the "I" Story *Who are you to tell me who I am?* By Keba Seboatane.

In other instances survivors have often been uncomfortable or unwilling to disclose personal details. Limitations in health care provision can be attributed to lack of training and skills, as well as conservative attitudes of health care professionals, which should not impact or influence the level of service and care they provide to survivors.

The NPA's Thuthuzela Care Centres (TCCs)

Thuthuzela Care Centres (TCCs)[57] offer an integrated, progressive approach to addressing sexual violence, prevention, service provision, and support of rape survivors. TCCs are one-stop facilities for managing sexual assault cases and were introduced as part of South Africa's national anti-rape strategy. The facilities are aimed at reducing secondary trauma, improving conviction rates and reducing the cycle time for finalising cases at court level.[58]

There are two models of TCCs: the medico-legal and hospital-based models. These are characterised by different management structures and resource allocations. The medico-legal sites tend to be standalone centres that provide services beyond sexual assault care. The goal of the TCC model is to effectively address the medical and social needs of sexual assault survivors, reduce secondary victimisation, improve conviction rates and reduce the lead time for finalisation of cases.[59]

Located in public hospitals, the hospital-based models aim to provide survivors with a broad range of essential services - from emergency medical care to counselling to court preparation - in a holistic, integrated and survivor-friendly manner. Services offered by the TCCs include: reception and comforting of client; information counselling on services and procedures; history taking and medical-legal examination; prophylaxis and treatment for pregnancy, STIs and HIV; bath or shower, refreshments and change of clothing; transportation home or to safe shelter; referrals; and follow-up support.

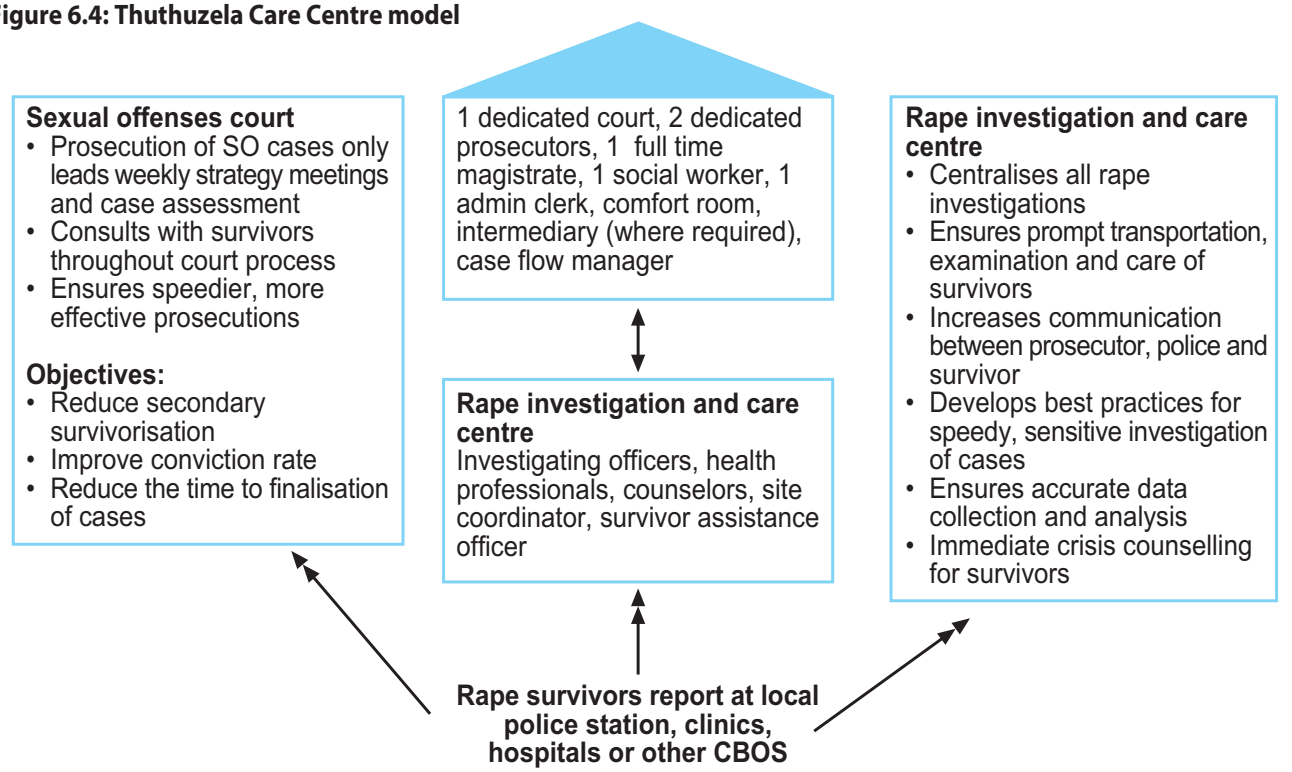
By early 2011 37 TCCs had been established nationwide. TCCs are located in communities where there is a high recorded incidence of rape: 10 213 sexual offences were reported at TCCs across the country in the period 2009-2010. As there are about 50 000 to 55 000 reported

TCC clients are able to open a case on-site, give their statement to the police, and/or receive longer-term psycho-social counselling and other support services.

Adopted from NPA brochures

[57] Thuthuzela, an IsiXhosa term meaning "comfort", used in the context of providing a caring environment in the midst of hurtful experiences experienced in rape and sexual assault cases. According to the NPA SOCA Unit, the word "comfort" awakens feelings of warmth, freedom from emotional and physical concerns, safety, and security, being pampered and cared for and, above all, reinforcing dignity, hope and positive expectation, all of which are attributes and feelings that are realised in the establishment of the Thuthuzela Care Centres.
[58] NPA, 2010.
[59] NPA, 2010 www.npa.gov.za

Figure 6.4: Thuthuzela Care Centre model



cases of rape annually, this means that about one in five reported rape cases is being attended at these specialised facilities.

Five Thuthuzela Centres are in operation in public hospitals in Gauteng: Chris Hani Baragwanath Hospital in Soweto; Sedibeng Region in Sebokeng; Kopanong Hospital; Mamelodi Hospital; Natalspruit Hospital in Katlehong and Tembisa Hospital.[60]

Evaluation of health services in TCCs

A 2007 study assessed the extent to which health care services provided by TCCs comply with the National Guidelines for Sexual Assault Care, with an emphasis on HIV-related issues.[61] All sites provided VCT for HIV; however, the quality of counselling varied from site to site. The PEP starter pack was not offered to patients who postponed testing for HIV, with the exception of one site. Patients were also not provided with the full 28-day pack of PEP after the starter pack, which is not consistent with national and international guidelines.[62]

It was common for patients not to return for follow-up and testing, linked to the fact that most centres do not provide support and incen-

[60] NPA 2011.
[61] USAID South Africa Program in Support Of PEPFAR: Thuthuzela Care Centres FY06.Final Report on the Compliance Assessment of the Thuthuzela Care Centres with National Department of Health Guidelines for Managing HIV in the Context of Sexual Assault .31 July 2007.
[62] Ibid.

tives for patients to return. Most centres did not have skilled personnel to deal with children and patients with special needs, although children formed a large proportion of the clientele. Many doctors were not adequately trained in dealing sexual assault cases and there were vacant forensic nurse positions in some of the sites. These gaps compromise the delivery capacity for quality services. It was also noted that some sites were not well designed for protecting patients from secondary victimisation. It is critically important that the health care aspect of TCCs meet the same high standards as the legal side of care, training, support and retention of staff.

Sexual Offences Courts (SOCs) attached to TCCs

The SOA provides a legal framework for an integrated approach to the management of sexual offences to reduce secondary trauma to survivors. TCCs are linked to sexual offences courts, which are staffed by prosecutors, social workers, investigating officers, magistrates, health professionals, NGOs and police, and located in close proximity to the centres. The NPA Sexual Offences and Community Affairs (SOCA) unit works with specialised prosecutors positioned in the sexual offences courts to develop best practices and policies to eradicate secondary victimisation of women while improving capacity to prosecute sexual offences and domestic violence cases.

Sixty three Sexual Offences Courts have been established nationwide, with the staff comprising a committed cadre of prosecutors, social workers, investigating officers, magistrates, health professionals and police, and some located in close proximity to the TCCs. The extent of involvement of the courts in addressing gender violence crimes has been observed in the findings of a preliminary report which states that sexual offences constituted 22-24% of court cases nationally in 2003 and 2006.[63] Furthermore, prosecutors spent 40-90% of their time on sexual offence matters either in courts or civil society meetings in the Eastern Cape and KwaZulu-Natal. The specialised courts performed well in relation to conviction rates, reaching an average of 70%, compared to the overall average of about 7%. Sexual Offences Courts linked to TCC's performed even better.

Specialised courts dealing with sexual offences have been stationed in TCCs. *Photo: Gender Links*

[63] Braam T & Lawrence B. (2009) National Audit of Multi Disciplinary Services in South Africa -presentation on preliminary findings and recommendations. Sexual Offences Indaba Conference. 18 May 2009.

The effectiveness of the specialised courts as opposed to the general courts is strong motivation for the rolling out of more sexual offences courts provincially and nationally. According to the Department of Justice and Constitutional Development's 2009-2010 annual report, the department developed a draft policy in consultation with Justice, Crime Prevention and Security Cluster Departments and regions to integrate sexual offence courts into the mainstream courts. The draft policy seeks to strengthen and roll out the specialised services to mainstream courts in provinces.[64] The endorsement of the draft policy and its implementation will lead to improvement and increase available specialised courts which are currently disproportionate to the need.

Community apathy

GBV is often considered a private matter as illustrated in the excerpt from Puni Matsimbi's "I" Story entitled *Finding strength is not easy:* "People came to watch with none offering any help. I was embarrassed and humiliated by the beatings in front of the people. My son tried pleading with him to stop, but his father threw him away. After beating me, he again ran away because he feared arrest. He was given another suspended sentence, but he never went to jail."

Matsimbi's experience is not unique. Findings show that community members often witness abuse but choose not to intervene, treating the incident as a private affair.

Community members should be encouraged to intervene in GBV cases and not "look away". *Photo: Colleen Lowe Morna*

[64] http://www.justice.gov.za/reportfiles/anr200910/anr2009-2010_part2.pdf.

The survey asked both men and women if they had witnessed violence against women in their communities or if they had ever talked about domestic violence. Those that had witnessed violence were then asked if they had intervened in some way.

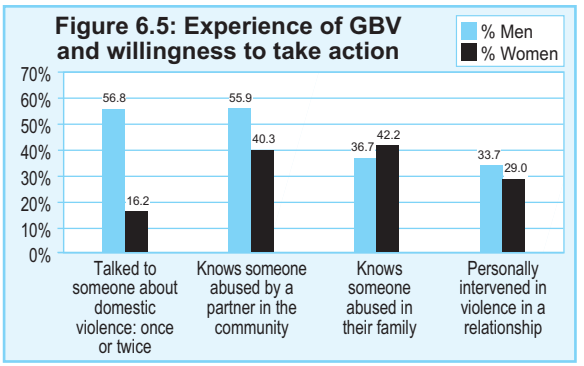


Figure 6.5 shows that although many participants knew an abused person, in either their family or community, many did not intervene. This illustrates that communities still view GBV as a private affair, which can also be seen as condoning this violence. The men surveyed were more likely to know about GBV in their community and, when they did know, to intervene.

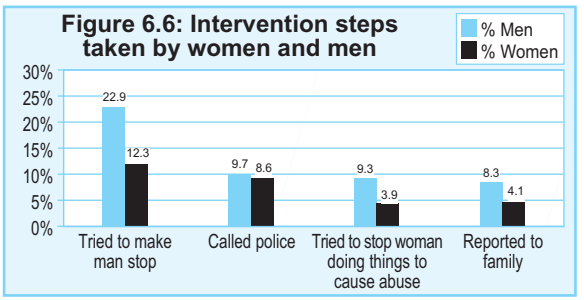
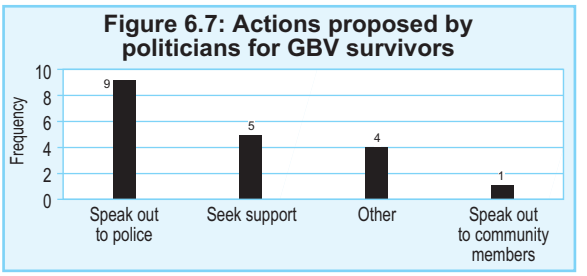


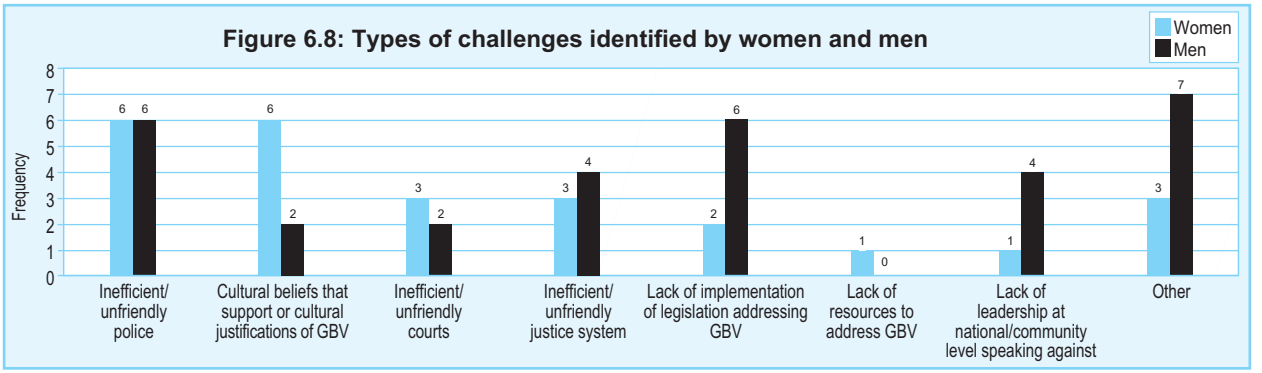
Figure 6.6 illustrates that the most common intervention involved the interviewee attempting to stop the man from abusing his partner. Only one in ten interviewees reported the abuse to police. In some instances, the community is supportive but does not want to involve the law, or may be reluctant to "harm" the perpetrator.

Challenges in addressing GBV



The political discourse analysis interrogated what advice leaders give to survivors of gender violence. Figure 6.7 shows that politicians most commonly tell GBV survivors to speak to police. This reflects a degree of superficiality on the part of politicians, who prefer not to engage with more complex support strategies such as counselling and rehabilitation. Most abused women prefer not to involve police, as reflected in the finding of the prevalence survey that only 3.9% of rape survivors reported the crime to police. Others who did not report to the police shared their experience with family or friends. Politicians need to understand and recommend different types of survivor and survivor support services. There are many possible responses to these crimes, much more than just a reliance on policing. One in 20 speeches identified the possibility of a community response by encouraging survivors to speak to other community members.

Individual actions recommended by politicians



Ironically, Figure 6.8 illustrates that both women and men politicians identified ineffective or unfriendly police officers as one of the main challenges to addressing gender-based violence (12 speeches). Eight speeches mentioned cultural beliefs that condone GBV; and five mentioned a lack of implementation of legislation that addresses GBV.

Conclusions

The majority of GBV survivors do not go to police or health services and those who do, fail to get the full range of services. It shows that the most effective services are obtained from the TCCs, linked to Sexual Offences Courts, but these are insufficient to service reported cases, let alone those that do not enter the formal system.