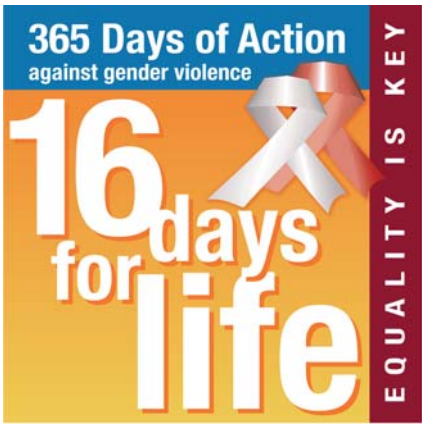
CHAPTER 9
INTEGRATED APPROACHES

Multi sectoral reference group set up to guide the Limpopo violence against women baseline research. *Photo by Gender Links*

Key facts

- South Africa has a National Action Plan for addressing GBV that was launched in 2007.
- Major challenges to the implementation of the NAP has been the lack of budgetary allocations and limited decentralisation to provincial and local government levels.
- The National GBV Council was inaugurated to ensure the implementation of the NAP.
- Integrated Victim Empowerment Policy (IVEP) recognises the importance of victims and all stakeholders, both in the public and private spheres, who deliver services to victims.
- Only two of the five TCCs located at hospitals remain fully operational namely Tshilidzini and Mangkweng TCC.
- In the period 2011-2012 Tshilidzini handled 420 sexual offences and 1096 DV cases.
- The ZTVA model is an example of a community based integrated approach for addressing GBV.

In May 2006, government and civil society stakeholders gathered at Kopanong to develop a National Plan of Action to end GBV. The conference led to two outcome documents: the Kopanong Declaration and the National Action Plan to End Gender Violence (NAP). Participants acknowledged that GBV is a complex issue which calls for strategically coordinated policies and actions augmented by the participation of both the government and civil society.[40]



This chapter focuses on integrated approaches facilitating a multi-sectoral response to GBV at national, provincial and local levels. It elaborates on structures exhibiting multi-sectoral collaboration between health, police, courts and social services to provide quality, sensitive treatment to victims at all three levels. Stakeholders taking part in desktop research and primary qualitative data collection derived evidence from these policies or structures.

The 365 Day National Action Plan to End Gender Violence

The Kopanong Declaration acknowledged that the 16 Days of Activism is not sufficient to address GBV and that a more comprehensive and sustained approach is necessary, including prevention, support, and response. The proposed NAP set targets, indicators and timeframes through which to monitor the impact of interventions addressing violence against women and children (by both government and civil society).

The plan is anchored on the recognition that no single sector, government ministry, department or civil society organisation is by itself responsible or has the singular ability to address this challenge. It is envisaged that all the South African government departments and civil society organisations will act as stakeholders and use this National Action Plan as the basis to develop their own strategic and operational plans to ensure unity of purpose and cohesion of efforts to achieve maximum impact in the process of eradicating this scourge.[41]

Evaluation of the 365 NAP

The Commission for Gender Equality (CGE) undertook a project in 2012 to monitor the implementation of the NAP. It set out to determine the extent to which the 365 Days campaign has been implemented since inception and identify key constraints and gaps in the implementation of the NAP and establish the effectiveness of programmes.

Since the official launch, proper implementation of the plan is still fragmented and uncoordinated. One major impediment has involved allocation of resources for implementation, especially given that when stakeholders launched the plan they did not conduct a budgetary vote for it. Other limitations include the level of civil society engagement and the lack of comprehensive monitoring and evaluation strategies for the plan (365 Day National Action Plan to End Gender Violence, 2007).

The National Council against GBV

Deputy President Kgalema Motlanthe launched the National Council against GBV on 10 December 2012 in Rustenburg.[42] Motlanthe chairs the council, which is championed by Minister of Women, Children and People with Disabilities Lulu Xingwana.

The council is a national multi-sectoral structure composed of 20 members from government and civil society. Sectors represented in the council include civil society organisations dealing with violence against women and children, religious organisations, traditional leadership, members of the women's

[40] http://www.unicef.org/southafrica/SAF_resources_365daysdeclaration.pdf
[41] http://www.unicef.org/southafrica/SAF_resources_365daysdeclaration.pdf
[42] http://www.services.gov.za/services/content/news/GenderBasedViolence/en_ZA

movement, academic and research institutions and government across all spheres and the South African Local Government Association.

The council has a mandate to provide strategic guidance and to monitor the implementation of all programmes dealing with the elimination of GBV in the country. More specifically, the council has been charged with the following responsibilities:

- To drive the implementation of the 365 Days National Plan and advise government on policy and intervention programmes;
- To strengthen national partnerships in the fight against gender-based violence;
- To create and strengthen international partnerships on gender-based violence; and
- To monitor and report progress on initiatives aimed at addressing gender-based violence.

Minister of Women Children and People with Disabilities Minister Lulu Xingwana briefs media on gender-based violence and turn-around strategy. *Photo courtesy of Google Images*

The NPA Sexual Offences and Community Affairs (SOCA) and management of the Thuthuzela Care Centres (TCCs)

The SOCA develops strategy and policy relating to sexual offences, domestic violence, human trafficking, maintenance matters and young offenders. Thuthuzela[43] Care Centres (TCCs) 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 South Africa introduced them as part of its national anti-rape strategy. The facilities aim to reduce secondary trauma, improve conviction rates and reduce the cycle time for finalising cases at court level.[44]

South Africa has two TCC models: the medico-legal and hospital-based models. Different management structures and resource allocations characterise each.

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.[45]

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.

[43] *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.

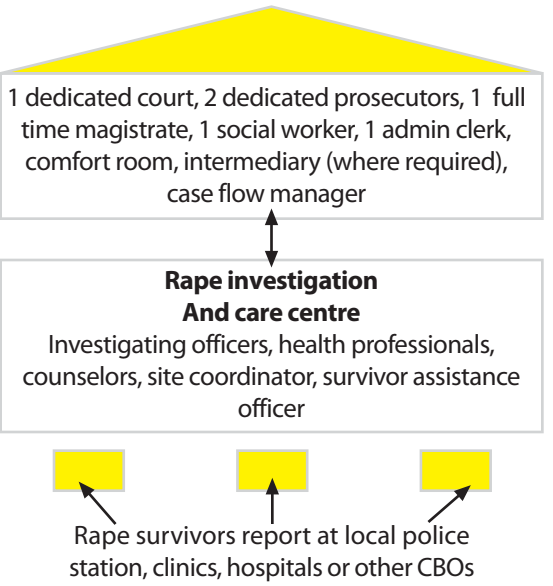
[44] NPA, 2010.

[45] NPA, 2010 www.npa.gov.za

Figure 9.1: Thuthuzela Care Centre model

Sexual offenses court
- Prosecution of SO cases only leads weekly strategy meetings and case assessment
- Consults with survivors throughout court process
- Ensures speedier, more effective prosecutions

Objectives
- Reduce secondary victimisation
- Improve conviction Rate
- Reduce the time to finalisation of cases



Rape investigation and care centre
- Centralises all rape investigations
- Ensures prompt transportation, examination and care of survivors
- Increases communication between prosecutor, police and survivor
- Develops best practices for speedy, sensitive investigation of cases
- Ensures accurate data collection and analysis
- Immediate crisis counselling for survivors

Thuthuzela Care Centres operate best in public hospitals close to communities where the incidence of rape is particularly high. They are also linked to sexual offences courts, which are staffed by skilled prosecutors, social workers, magistrates, NGOs and police, and located in close proximity to the centres (NPA Annual report 2011/2012). Since 2010 the number of sites providing TCC services increased from 45 to 52.

Commenting on the establishment of TCCs in the rural areas, the Minister of Justice and Constitutional Development said government has already established 26 TCCs in the rural areas. Government defined a TCC as rural if the majority of the cases reported come from farming communities or rural areas.

Use of TCC services

While the police received 64 472 cases of sexual offences in 2011-2012, less than half of these survivors (28 557) accessed services at the TCCs during the same period.

Table 9.1: Change in number of cases reported at TCCs between 2010-11 and 2011-12: National

Criteria	2010-11	2011-12	Actual difference	% difference
Number of new cases (national)	20 496	28 557	8061	39.3
Number of cases designated to case managers at court (national)	9716	10 949	1233	12.7
Number of cases finalized at court (national)	1761	2180	419	23.8

Source: (NPA Annual report 2011/2012).

Table 9.2 shows an increase in the number of reported cases and improvement in case management from the 2010-11 financial years to the 2011-12 financial years. Researchers logged a 39% increase in reported cases and a 24% increase in finalised cases between the two financial years. However, less than half of the cases reported in these two years went to court and got allocated to case managers.

While the courts received 10 949 sexual offences in addition to outstanding cases, only a small proportion (2180) reached completion. These findings speak to the prolonged times currently used to complete cases and to the huge court backlogs. There is also an insufficient number of magistrates or court officials to deal with the influx of sexual offences cases.

Conviction rates

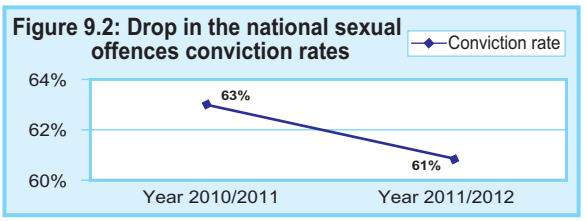


Figure 9.2 shows the average conviction rate of sexual offences prosecuted at sites linked to TCCs dropped from 63% to 61% between the two financial years (NPA annual report 2011/2012). According to the DOJ&CD annual report 2012, this drop can be attributed to various factors including case flow management being dealt with by presiding officers, a substantial drop in the number of dedicated courts, a decrease in specialised services and a considerable increase in sexual offence matters reported at TCCs.

Referrals

TCC referred more than half (57%) of reported cases to court for prosecution.

TCCs in Limpopo Province

To date, Limpopo has five TCCs: Mangkweng TCC at Mangkweng Hospital in Polokwane, Tshilidzini TCC at Tshilidzini Hospital in Thohoyandou, Nkensani TCC, Musina TCC and Mokopane TCC. Musina and Mokopane TCCs are not fully operational.[46]

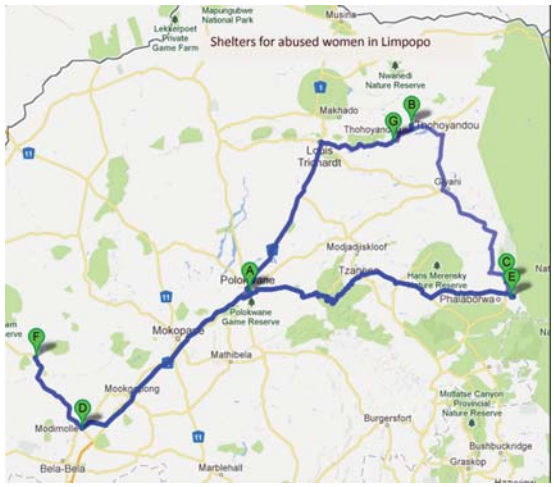


Table 9.2: Number of TCCs in Limpopo

Province	Total sexual offences reported to police 2011/12)	Number of TCCs	TCCs in Limpopo	Name of hospital	Location: rural/urban
Limpopo	5669	5	Mangkweng TCC		Rural
			Tshilidzini TCC	Mangkweng	Rural
			Musina TCC (not fully operational)	Tshilidzini	Rural
			Mokopane TCC (not fully operational)	Musina	Rural
			Nkhensani TCC (not fully operational)	Mokopane	Rural
National Total	**64 472**				

Sources: SAPS crime stats report 2011/2012; DOJ&CD Parliamentary question 1580 (June 2012).

Table 9.1 shows that the total number of TCCs in Limpopo province is not enough to cater for all the sexual offences reported to the police in the year 2011/12. Based on the number of sexual offences reported by the SAPS (2012) and the total number of TCCs in each province, approximately one victim per 1000 can access the TCC in Limpopo. This means there is a disproportionate number of TCCs compared to need.

[46] http://www.unicef.org/southafrica/protection_5080.html

Case study: Tshilidzini TCC

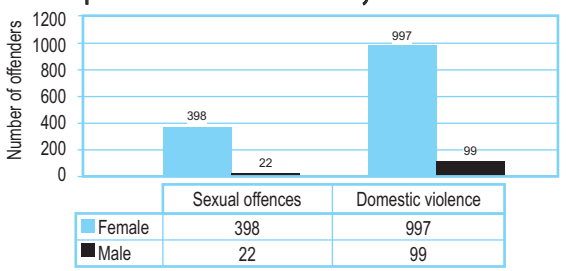
Photo courtesy of Google Images

Tshildzini TCC is situated at Tshilidzini Hospital in Thohoyandou. Services offered include shelter services and referrals to police for protection orders and/or to the magistrate court.

Shelter services

Despite being designed as a one-stop centre, over the years it has been operating as a shelter. On average, about 30-40 people report cases each month. The TCC has four bunk beds for a total of eight beds that can be used. Due to limited number of beds, in some instances victims have to share beds or sleep on mattresses on the floor, especially in the case of families (mother and children).

Figure 9.3: Sexual offences and domestic violence acts reported at the Tshilidzini TCC in the year 2011-2012

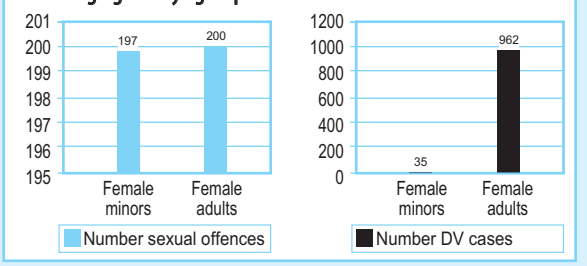


Source: Tshilidzini TCC.

Figure 9.3 shows that between 2011 and 2012, victims reported 420 sexual offences and 1096 DV cases at the TCC. Women victims reported the majority of sexual offences cases (95%) and DV cases (91%). Overall, the number of GBV cases being handled at the centre is increasing, putting more pressure on both human and other resources such as beds and space as evidenced by some victims sleeping on the floor (Direct communication with staff member Nicholas Kwinda).

Figure 9.4 shows that almost equal proportions of adult and minor sexual offences victims report to the TCC. Adult victims accounted for 200 of the sexual offences reported in the period under review while female minors reported 197 of the cases. These statistics provide further evidence of the fact that young survivors of sexual offences comprise a large share of those accessing TCCs in the country. Adult women report the majority of DV cases.

Figure 9.4: Domestic violence and sexual offences among females segregated by age reported to Tshilidzini TCC 2011-2012



Source: Tshilidzini TCC.

Figure 9.5: PEP uptake by victims of rape at the Tshilidzini TCC 2011-2012

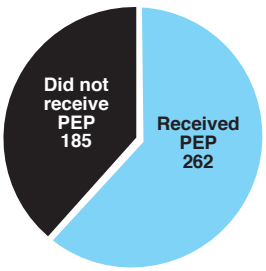


Figure 9.5 shows that more than half (62%) of those who reported sexual violence at the TCC received PEP. Survivors often arrive at the centre more than 72 hours after the incident, which is one of the reasons they may not access PEP services.

Challenges

There is currently no case manager to deal with conviction issues. Another challenge is the high rate of case withdrawal by the victims. It is common for victims to open a protection order which they later nullify - after some time victims often return to the TCC having experienced recurrent acts of GBV.

To curb this, the TCC hired social workers to assist in such matters by providing counselling and advice on legal matters. Due to this move, the number of referrals to the magistrate court and to the police has decreased since social workers deal with some of the cases. The TCC lacks office space and resources. For example, it has just four bedrooms, two of which also accommodate social workers (Direct communication with Tshilidzini TCC coordinator).

Challenges faced by Limpopo TCCs

- Victims cannot be kept for longer than two weeks in the current premises.
- There is also no clear tracking system to follow a case from when it comes to the TCC system until conviction. It complicates measuring the success of the TCC system.

The National Integrated Victim Empowerment Policy

The Integrated Victim Empowerment Policy (NIVEP) forms part of the strategic efforts of the South African government to prevent crime and to create a peaceful crime-free country. The IVEP recognises the importance of victims and all stakeholders, both in the public and private spheres, who deliver services to victims. The policy therefore provides for the coordination of all activities and efforts by various government departments and civil society. It creates a framework to guide and inform the provision of integrated and multi-disciplinary services to address the needs of victims of violent crime.

More specifically the IVEP aims to:
- Give strategic direction to those providing services to victims of crime and violence;
- Identify the roles and responsibilities of various role players; and
- Create a common understanding of victim empowerment amongst various state departments, victims, perpetrators, NGOs and CBOs and individual members of the community (IVEP Draft 2007).

Intervention strategies

The guiding principles for the NIVEP have been embodied in values that determine the nature and good quality services for victims, respecting the rights of the victims and applying the principles of both "Ubuntu" and "Batho Pele." The NIVEP has core intervention strategies based upon the concept of a victim-centred approach which avoids secondary victimisation. These strategies apply to all sectors involved in the empowerment of victims.

The National Victim Empowerment Programme (NVEP)

Stakeholders created the NVEP in 1998 after the National Crime Prevention Strategy (NCPS) acknowledged the need to promote and implement a victim-centred approach to crime prevention.

They formally launched VEP in August 1998, however full implementation only started in January 1999. This programme aimed to make integrated criminal justice victim-friendly and to abate the negative effects of crime and violence on the victims.

To ensure integrated and coordinated services between government departments (at various levels) and civil society, the NVEP is comprised of various structures. These include an integrated inter-sectoral Victim Empowerment Management Team (VEMT) consisting of representatives from the national departments of health, correctional services, justice, education, SAPS with social development as the lead and coordinating department.

The VEMT is responsible for determining the strategic direction with regard to the management of the NVEP and to ensure that respective departments address all issues pertaining to victims. The following table shows the different roles of the departments within the VEMT.

Table 9.3: Departmental responsibilities within the VEP	
Department	**Responsibility**
The Department of Health	Providing a professional and accessible service to victims of crime and violence who approach hospitals, clinics, primary health care centres or crisis centres for assistance.
The SAPS	Providing a professional and accessible service to victims/survivors of crime and violence during the reporting and investigation of crime.
The Department for Social Development	Coordinating the roles across the relevant departments.
The Department of Justice and The National Prosecuting Authority (NPA)	Responsible for the professional treatment of victims of crime and violence, and witnesses to facilitate optimal participation on the criminal justice process.
The Department of Education	Prevents the victimisation of children in the school environment. In the event of victimisation the departments facilitates immediate access to other relevant support structures (such as the SAPS and Social Development) act against perpetrators, protect child against further victimisation.
Civil Society Organisations (CSOs)	In partnership with government, civil society plays a major role in advocating for victims' rights and providing services to victims. Other CSOs are involved in increasing and expanding the frontiers of knowledge in the field of victim empowerment, especially in the area of crime prevention, trauma and post-traumatic stress disorder.

Source: Parliamentary Monitoring Group.

The integrated service delivery model is used to meet such a holistic demand. The levels/methods of services rendered address the victim's physical, psychological, social, educational and emotional needs.

1. ***The primary prevention method*** includes primary methods which aim to stop violence before it occurs. Services rendered should be preventative in nature and in the form of awareness campaigns and advocacy programmes. Staff members conduct various outreach programmes to create better community awareness of those crimes affecting victims, and to allow them to take responsibility for addressing the problem and also acknowledging that violence is not a domestic problem, but a community problem. This can be facilitated by distributing promotional material and pamphlets.
2. ***Early intervention methods*** include parental skills development, debriefing and defusing, therapeutic services focusing on empowerment of women and children exposed to mild or moderate domestic violence within the onset phase of gender-based violence. Staff members empower women with knowledge about their rights and about domestic violence, sexual assault and abuse based on the outcome of the IDP/IAP developed during the victim and the social worker's contact.
3. ***Statutory services*** include all court services rendered in the form of court reports at pre-trial and pre-sentencing stage. Services include referral for protection order as well as the compilation of victim impact statements. Statutory services are categorised into:
   a) Sexual assault cases: pre-trial and pre-sentencing reports addressing the developmental stages of a child victim, as well as the impact of the trauma on the victim. The child should be accompanied by a responsible adult family member.
   b) Domestic violence cases: victim impact statements are completed and submitted to court, referral and assistance in terms of application for protection orders, divorce and custody matters.

c) Human trafficking cases: court reports clearly state the assessment in terms of identifying the victim and indicating the impact of trauma on the victim.
d) Child abuse cases: in terms of child abuse cases and children with behavioural problems, assessments at the centre seek to observe the behaviour of the child and render rehabilitation programmes. Once that has been done, a report is compiled for the children's court with recommendations related to the future of the child. This reflects the findings and observations of the centre staff.

4. ***Continuum of care services/methods*** include shelters to accommodate women and children affected by gender-based violence, children under the age of 18 affected by sexual assault, sexual abuse and human trafficking. Services rendered include those of a multi-disciplinary approach that is constituted by: social workers, permanent/contracted psychologists, nurses/doctors, court preparation assistants, prosecutors and police, all working in a multi-disciplinary team to assist victims to prepare and mount successful cases for prosecution.

Figure 9.6: The NVEP victim centred approach

South Africa Department of Social Development
Overview of the Victim Centered Approach

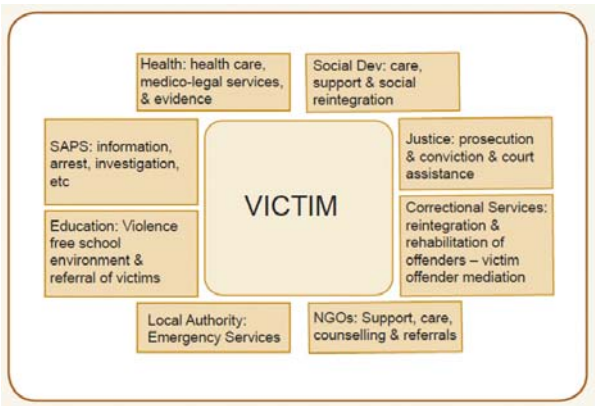


Figure 9.6 demonstrates how the different departments work in unison within a victim centred approach. The partnership between various government departments and civil society on service delivery to victims of crime is prerequisite to the success of the integrated VEP. Each structure is expected to develop its own strategies to address the needs of victims. Such strategies should be coordinated within the department and between relevant departments to ensure a holistic approach to service delivery with no duplication of services and service delivery, thus ensuring optimal use of the limited resources (Integrated Victim Empowerment Policy Draft, 2007).

Evaluation of the VEP programme by UNDOC

The VEP has encountered various challenges since inception, some of which include the lack of monitoring and evaluation mechanisms and inadequate facilities for victims of crime and the broad geographic spread of such facilities. A glaring gap is the inadequacy of shelters to accommodate victims in the rural areas.

Victims do not always receive the type of services they deserve and high staff turnover hampers effectiveness and progress. The programme is short-staffed and the counsellors and social workers currently available do not tally with the number of victims.

Polokwane Victim Empowerment Centre poster.

Lack of a strong communication and marketing strategy has also impeded the effective administration of the programme. Although the programme has managed to strengthen coordination between government departments and CSOs, several other relevant departments have not been fully involved. For instance the Department of Education is not actively participating in VEP activities. However, over the years government has made efforts to strengthen the programmes (UNODC - South Africa's Victim Empowerment Programme - Final Independent Evaluation).

Photo courtesy South Africa Government Online

Victim empowerment at provincial level - Limpopo Department of Social Development

One stop centres

The National DSD department has established one stop centres as part of the VEP. These centres offer integrated services to victims of violence, abuse and crime. Unlike shelters, one stop centres only provide emergency accommodation.

The centres also provide a range of services such as counselling, medical attention, legal advice and support for survivors of violence. They also offer rehabilitation services, including counselling and support groups for male perpetrators as well as potential perpetrators in order to break the cycle of violence. After assessing each situation, victims can be referred to a shelter if it is too risky to send them home. The Khuseleka one stop centre, the only one stop centre in Limpopo, is explored in further detail in the next case study.

VEP case study: Khuseleka One-Stop Centre

The Khuseleka model is a multi-sectoral approach being implemented by the Department of Social Development in collaboration with the UNODC and EU under the Victim Empowerment Programme. Other key government departments and institutions include the Departments of Justice and Constitutional Development, Health, the National Prosecuting Authority (NPA), South African Police Services and civil society organisations. Adapted from existing models, Khuseleka stands as a good example of a partnership between government, development agencies and civil society organisations in the country.

The name Khuseleka is derived from the Zulu word which means protection. The centre is an initiative of the Department of Social Development's VEP that came about as a way of responding to the needs of women and children, especially in poor black rural areas and communities that experience GBV.

Services

The 24-hour centre aims to provide integrated services for women and children victims of violence, such as trauma counselling and psychosocial support, health care, police services, legal assistance and shelter services.

Medico-legal services include ensuring medico-legal professionals have been based at the centre. These people can assess the physical condition and obtain baseline vital signs, take a brief history of events, take a sexual assault kit, conduct on-site HIV testing and counselling, provide pre- and post- counselling advice and providing documentation to the victim. All these would be applicable if, and only if, there is commitment from all the core stakeholder departments.

Capacity
The centre currently has the capacity to house up to 30 adults and 12 children for up to six months.

Funding
The centre is not only budgeted for by the Department of Social Development, but all the core stakeholder departments contribute in the form of remuneration and use of human resource and service tools used at the centre. The business sector also plays an important role by donating in kind. Some community members also make donations.

Partnerships
Adapted from existing models, Khuseleka stands as a good example of a partnership between government, development agencies and civil society organisations. Other key government departments and institutions involved in running the centre include the Departments of Justice and Constitutional Development, Health, the National Prosecuting Authority (NPA), South African Police Services and civil society organisations.

Achievements
The centre has conducted successful awareness campaigns for prevention and advocacy programmes. It successfully reached 1762 people during the crime victims' rights week in September 2012 and 2876 people during 16 Days of Activism from 25 November - 10 December 2012. It also participated in the Take Back the Night Campaign at which one of the survivors from the centre confidently addressed the crowd about taking charge and control on preventing and bringing about a paradigm shift by breaking the gender-based violence cycle.

Challenges
While the one stop centre model is supported at national level, there remains a lack of buy-in and understanding of the department roles needed at the provincial level. Other challenges include slow pace in police case investigations and lack of competency among some support staff.

Replication
Stakeholders have plans to open multiple one-stop centres across South Africa. The Khuseleka One-Stop Centre represents the first of many in all nine provinces. On 5 October 2011, Minister Bathabile Dlamini officially launched the Limpopo Khuseleka centre. On 29 November 2011, stakeholders in Vryburg, North West Province, launched the second one-stop centre there. Others now exist in Gauteng, Eastern Cape, Northern Cape and Mpumalanga.

Next steps
The next major step required is the establishment of the centre advisory board, which should constitute members from the core stakeholder departments. The centre also needs to recruit volunteers for general support.

Adapted from the 2013 SADC Gender Protocol Summit and Awards submissions

Coordination by the LDoH

At a provincial level, Irish Aid is working with the Limpopo Provincial Department of Health and Social Development (LPDOHSD) and NGOs to support their responses to GBV. The LDoH assists in planning and implementing programmes geared towards a provincial campaign that will strive to:

- Increase coordination and improve relations between government and civil society within the province;

- Strengthen capacity of the department to mainstream gender and contribute to efforts aimed at reducing violence;
- Strengthen community structures to better respond to violence against women; and
- Educate people on the issue of GBV and challenge the negative attitudes and beliefs that perpetrate GBV in Limpopo.

In addition, Irish Aid is also funding the training of health care officials in the province to enable them to properly gain evidence in the immediate aftermath of rape.

Zero Tolerance Village Alliance Project in Vhembe and Mopani: Partnership between LDOH, TVEP and GL to prevent GBV at a community level

The ZTVA programme is aimed to enable behavioural change by building empowered and supportive environments in which victims of sexual, domestic and child violence, and People Living With HIV and AIDS (PLWHA), feel secure to speak out and exercise their rights. The process involve training community based organisations (CBOs) to undergo seven day training on the ZTVA model. Training exercises provide each CBO participant with the skills and knowledge to support the required ZTVA implementation activities. Activities include holding workshops, community dialogues, door-to-door campaigns and focus group discussions. Positive results and the change in behaviour have been observed in the participating villages.

Case study: Description of TVEP's Zero Tolerance Village Alliance (ZTVA) prevention training

The ZTVA is a holistic approach to the eradication of gender and child violence. The strategy targets all elements of "hot-spot" villages, to ensure that everyone in the community is empowered on their rights and responsibilities. The project includes the establishment of safe houses and support groups and aims to generate community pride as a means of combating crime. It requires male role models to take a public oath committing them to the eradication of gender and child violence, following which they will be awarded a Badge of Honour. Women who have "broken the silence" will also receive a Badge of Courage at the same ceremony.

Break the Silence campaigns, plays and public sensitisation workshops

The campaign trains volunteer campaigners (Advocacy Officers) to mobilise communities in the ZTVA villages and respond to requests from community structures such as traditional councils, schools and churches. Interventions include campaigns, workshops and/or plays performed by unemployed youths. The organisation has fostered good working relationships with national and community radio stations and newspapers.

Help desks

The campaign places volunteer advisors at nine rural clinics and at the central office in Sibasa. The role of the volunteers is to:

- Promote the Break the Silence ethic and encourage access to ART;
- Identify orphans and vulnerable children and refer accordingly;
- Facilitate access to safe pregnancy termination services, female condoms, social grants and/or food parcels; and
- Report abuse or malpractice.

Survivor workshops
The team invites women and youths who report family violence to either of the trauma centres to a series of two workshops at which they learn about their rights as well as coping skills. Transport is provided and participants can bring a friend or family member as company.

TVEP's "Survivors Rights" publications
The coordinators of this project realise that for a message to be sustainable it must be incorporated into the Life Skills curriculum for all schools. To this end, TVEP has developed and piloted workbooks for learners in partnership with the Department of Education. In order to also cover younger children, and to encourage reporting of child abuse, TVEP builds the capacity of educators at crèches and preschools and provides them with educational posters. It also distributes stickers carrying appropriate slogans to the children and information leaflets on child abuse (in the two languages spoken in the region) to parents.

Sustainability and partnerships
TVEP has partnered with the trauma centres under the Department of Health since 2001 and formed partnerships with government departments such as Social Development, Home Affairs, South African Police Services and the Department of Public Prosecution. This work has demonstrated that the ZTVA model can be rolled out to many villages. The partnership has also afforded TVEP the value-added outcome of collaborating with other Vhembe district CBOs, thereby reducing the duplication of efforts while ensuring that quality service is provided to clients by all organisations. The project has also benefited the five targeted CBOs as they have been given the opportunity to participate in capacity-building exercises previously unavailable to them.

Achievements
TVEP and ZTVA teams have made significant progress in assimilating contextually-appropriate interventions and services into existing population groups. Partnerships created with police, government and like-minded CBOs have resulted in swift adoption by stakeholders. The ZTVA model is adaptable for use in other regions where traditional leadership is at odds with government mandates.

Main challenges
- Funding continuity;
- Human resource constraints;
- Technology limitations;
- Geographic access to marginalised regions;
- Dissonant ideologies between village leadership; and
- Sustained participation of chiefs.

Source:TVEP

Conclusion

Stakeholders have implemented several integrated approaches to fight GBV at national and provincial level that engage both government and civil society. These include the National GBV council, the 365 Day NAP, the IVEP and the Thuthuzela care centres. Despite these structures, widespread incidences of GBV remain

common and many survivors struggle to access the TCCS and one stop centres run as part of the VEP programme.

Challenges in operating and coordinating integrated structures and policies include lack of funding for the structures, poor harmonisation among structure members and poor monitoring and evaluation systems.

Some of the structures also remain inadequate and ineffective, including the TCCs, which refer less than half of GBV cases to the courts. This can act as a deterrent to survivors looking for justice or access to services. National level conviction rates for sexual offences have also decreased, which is another significant challenge.

Victims report more cases of domestic violence than sexual offences at TCCs, including the Tshilidzini TCC. Mostly women use the TCCs, but the number of female minors reporting cases is similar to the number of adult women. More than a third of survivors fail to access PEP, mainly due to the fact that they report to the TCC too late.

While the Khuseleka One-Stop Centre is ground breaking and the model is being rolled out to the rest of the country, there remains a great need for better and further coordination of VEP-related initiatives at provincial level.