The Gender Based Violence Indicators Study

Western Cape Province of South Africa

January 2014

Gender Links (GL) is a Southern African non-governmental organisation (NGO) that is committed to a region in which women and men are able to participate equally in all aspects of public and private life. This is in accordance with the provisions of the Southern African Development Community (SADC) Protocol on Gender and Development. GL achieves its vision by coordinating the work of the Southern African Gender Protocol Alliance formed around the sub-regional instrument that brings together all key African and global commitments for achieving gender equality. Working with partners at local, national, regional and international level, GL aims to:

- Promote gender equality in, and through the media and in all areas of governance.
- Develop policies and conduct effective campaigns for ending gender violence and HIV and AIDS.
- Build the capacity of women and men to engage critically in democratic processes that advance equality and justice.

GBV Indicators Research in Western Cape Province

ISBN: 978-0-9922433-1-9

Gender Links
9 Derrick Avenue
Cyrildene
Johannesburg
South Africa

Phone : +27116222877
Fax : + 27 11 (0) 622 4732
Email: gbvindicators@genderlinks.org.za
Website: www.genderlinks.org.za

Authors: Linda Musariri Chipatiso, Violet Nyambo, Mercilene Machisa and Kevin Chiramba
Editor: Helen Grange
Cover photo: Take Back the Night Mossel Bay Summit Study Visit, Western Cape, South Africa, 2013
Photo by: Ntombentsha Mbadlanyana
Design and layout: Debi Lee

Contents

List of tables

List of figures

Acknowledgements

The Gender-Based Violence (GBV) Indicators Project is a regional research study aimed at testing tools to measure and monitor various aspects of violence against women (VAW). The study tests the extent, effect and cost of VAW as well as current efforts to end it in light of the SADC Protocol on Gender and Development's target to halve levels of GBV by 2015. This is a report of a study conducted in Western Cape Province of South Africa in 2011.

Our appreciation goes to the 750 women and 742 men who consented to participate in this study.

GL is especially indebted to the 18 women who shared their personal testimonies or "I" Stories and agreed to have them published in this research. To protect their identity and to avoid any further suffering, the editors have referred to those who gave first-hand accounts using pseudonyms.

GL gives special thanks to the Saartjie Baartman Centre for assisting in collecting the "I" Stories. The voices of those most affected give this study power and urgency.

GL also commends Umhlaba Development Services for training researchers and overseeing the data collection of the prevalence and attitudes survey. Fourteen research assistants visited households and administered survey questionnaires in the Western Cape Province.

Thanks to Quintin Spies and Carl Fourie who programmed questionnaires and equipment. Spies provided invaluable technical support including the training of researchers on the use of the personal digital assistants (PDAs).

GL Chief Executive Officer (CEO), Colleen Lowe Morna, GL Deputy CEO, Kubi Rama, and former Justice Programme Manager, Loveness Jambaya Nyakujarah, conceptualised and raised funds for the project. Kubi Rama provided oversight and former GBV Indicators Research Manager, Mercilene Machisa, managed the research and stakeholder consultations.

Linda Musariri Chipatiso gathered and analysed the administrative data for the study and contributed in writing some chapters of this report. Violet Nyambo and Machisa analysed data from the different legs of the research and Musariri Chipatiso co-ordinated the writing and editing of all the chapters in this report. Kevin Chiramba assisted in writing and editing some sections of the report.

GL worked with the South African Medical Research Council (MRC) in the conceptualisation of the prevalence and attitudes household survey. Professor Rachel Jewkes, Director of the MRC Gender and Health Research Unit, and Nicola Christofides, initially with the MRC and later a senior lecturer at the University of the Witwatersrand School of Public Health, advised on and developed the survey research methodology and instruments. Nwabisa Jama Shai, former GL GBV Indicators Research Manager, contributed to the development of research tools.

We are deeply grateful to the following:
United Nations Trust Fund to End Violence against Women (housed within Unifem) for supporting the conceptual phase of this project, FOKUS, UKaid through the Department for International Development (DFID) and Norwegian Church Council, for funding the research and report.

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
AGC	Africa Gender Centre
ANC	African National Congress
BPA	Beijing Platform for Action
CBO	Community Based Organisation
CC&DW	Creative Consulting & Development Works
CEDAW	The Convention on the Elimination of All forms of Discrimination Against Women
CEO	Chief Executive Officer
CGE	Commission for Gender Equality
CSO	Civil Society Organisation
DFID	Department for International Development
DOH	Department of Health
DOJ&CD	Department of Justice & Constitutional Development
DSD	Department of Social Development
DV	Domestic Violence
DVA	Domestic Violence Act
DWCPD	Department of Women, Children and People with Disabilities
EA	Enumeration Area
FAMSA	Families South Africa
FCS	Family Violence, Child Protection and Sexual Offences Unit
GBV	Gender-Based Violence
GCIS	Government Communication and Information System
GDP	Gross Domestic Product
GEMSA	Gender and Media Southern Africa Network
GL	Gender Links
GMPS	Gender and Media Progress Study
HIV	Human Immunodeficiency Virus
ICD	Independent Complaints Directorate
IDMT	Inter-Departmental Management Team
IPID	Independent Police Investigative Directorate
IPV	Intimate Partner Violence
IPVPPF	Integrated Provincial Violence Prevention Policy Framework
IVEP	Integrated Victim Empowerment Policy
JCPS	Justice, Crime Prevention and Security Cluster
KZN	KwaZulu-Natal
LMs	Local Municipalities
MRC	Medical Research Council of South Africa
MP	Member of Parliament
NAP	National Action Plan to End Violence Against Women and Children
NCGBV	National Council Against Gender-Based Violence
NCPS	National Crime Prevention Strategy
NGO	Non-Governmental Organisation
NICRO	National Institute for Crime Prevention and Reintegration of Offenders
NOC	National Operations Centre
NPA	National Prosecuting Authority
NPO	Non-Profit Organisation
NRSO	National Register for Sexual Offenders
OMC	One Man Can
NIDA	National Institute on Drug Abuse
PCI	Project Concern International
PDA	Personal Digital Assistant
PEP	Post-Exposure Prophylaxis
PIA	Prevention in Action
PIPV	Perpetrator of Intimate Partner Violence
POs	Protection Orders
PSU	Primary Sampling Unit
PTSD	Post-Traumatic Stress Disorder
RAPCAN	Resources Aimed at the Prevention of Child Abuse and Neglect
RTI	Research Triangle Institute
SADC	Southern African Development Community
SAPS	South African Police Service
SAVE-	Sexual Assault Victim Empowerment
SGVH	Stop Gender Violence Helpline
SOA	Sexual Offences Act
SOC	Sexual Offences Courts
SOCA	Sexual Offences and Community Affairs Unit
STI	Sexually Transmitted Infection
TCCs	Thuthuzela Care Centres
TLAC	Tshwaranang Legal Advocacy Centre
UK	United Kingdom
UN	United Nations
UNECA -	United Nations Economic Commission for Africa
UNIFEM-	United Nations Development Fund for Women
VAW	Violence against women
VEP	Victim Empowerment Programme
VFR	Victim friendly room
VPUU	Violence Prevention through Urban Upgrading
WC	Western Cape
WCG	Western Cape Government
WCNOVAW	Western Cape Network on Violence Against Women
WHO	World Health Organisation

The Management and Research Team

Colleen Lowe Morna is CEO of Gender Links. A South African born in Zimbabwe, Lowe Morna began her career as a journalist specialising in economic and development reporting including as Africa Editor of the New Delhi-based Women's Feature Service. She joined the Commonwealth Secretariat as a senior researcher on the Africa desk in 1991, and later served as Chief Programme Officer of the Commonwealth Observer Mission to South Africa. Lowe Morna subsequently served as founding CEO of the South African Commission on Gender Equality. A trainer, researcher and writer, Lowe Morna has written extensively on gender issues in Southern Africa. Lowe Morna holds a BA degree in International Relations from Princeton University; Masters in Journalism from Columbia University and certificate in executive management from the London Business School. She has received awards from the Woodrow Wilson School of International Relations; the News-women's Club of New York and the Mail and Guardian newspaper in South Africa. In 2007, South Africa's Media Magazine named Lowe Morna runner up in the Media Woman of the Year Award. In 2013, CEO magazine named Lowe Morna the "most influential woman" in South Africa and Africa as a whole in the civil society category. A year later the University of Johannesburg awarded Lowe Morna honorary membership of the Golden Key Association that recognises excellence in academia and public service.

Kubi Rama is GL Deputy Chief Executive Officer. She is the former CEO of the Gender and Media Southern Africa (GEMSA) Network, where she managed the financial and institutional development of GEMSA. Previously, as Deputy Director and Network Manager of GL, she managed a new audience research project, coordinated the regional network, set up a virtual resource centre for media trainers, coordinated and sustained the 16 Days of Activism campaign, organised a regional media summit and mainstreamed gender as part of training curricula. Prior to joining GL, Rama worked in the Department of Journalism (Durban Institute of Technology) as a senior lecturer.

Linda Musariri Chipatiso joined GL in 2013 as the GBV Indicators Research Officer. As a Hewlett Fellow, Musariri Chipatiso completed her studies towards a Master of Arts degree in Demography and Population Studies from the University of Witwatersrand. She gained significant experience in data management and analysis using household survey data from various countries in Africa. She also holds a BA Honours degree in Theatre Arts from the University of Zimbabwe. Prior to joining GL, she worked as a resource mobilisation consultant at Sonke Gender Justice Network, where she focused mainly on proposal and report writing. She has also provided research consultation services to Seriti Institute, an organisation that focuses on community development in South Africa. As a demographer and population scientist, her career goal is to contribute to effective policies and evidence-based interventions that seek to address reproductive health, gender and migration issues in Africa and globally.

Ntombentsha Mbadlanyana joined GL as the Gender Justice & Local Government Facilitator on 1 March 2010. Before joining GL, she worked for the Provincial Government of the Western Cape in the Department of Social Development's head office, working for the Social Capital Formation Directorate. She is also a researcher, facilitator, gender activist and an academic with qualifications in Social Sciences. She holds a Bachelor of Arts degree in Women's & Gender studies as well as an Honours degree obtained at the University of the Western Cape, majoring in Social Sciences, Anthropology, English and Humanities. She is currently studying towards a Master of Arts degree in Women's & Gender Studies. She also worked as an intern at RAPCAN (Resources Aimed at the Prevention of Child Abuse and Neglect), an NGO in Cape Town, and volunteered at Triangle Project an organisation that focuses on the rights of lesbian, gay, bisexual, transgender and intersex people.

Violet Nyambo is the GL's Monitoring and Evaluation Officer. She has worked as an interviewer in various HIV and AIDS research projects at the The University of Zimbabwe-University of California San Francisco Collaborative Research Program's Women's Health Programme in Zimbabwe. Nyambo complements her research working experience with a Master degree in Demography and Population Studies attained at the University of the Witwatersrand. She has extensive knowledge in qualitative and quantitative data management and analysis and is a 2012 Hewlett Foundation Fellow. She also holds an Honours degree in Community Development from the University of Pretoria. Her main research interests are in sexual reproductive health, namely, family planning.

Foreword


Shaheema Mcleod: Director Saartjie Baartman Centre.

The Western Cape Department government aims to increase safety for all people in the province through effective oversight of policing, making safety everyone's responsibility and optimising safety and security risk management. The big question is are women safe in the Western Cape? Furthermore, is the government providing the right kind of service that is expected of it? Besides the province being the best performing in terms of infrastructure and economic development, it is still marred by high levels of inequalities including gender based violence.

The Western Cape GBV Baseline Study gives an insight on the current state of GBV in the province. The findings should be taken as an awakening by all relevant parties who are working towards improving the status of women as gender violence greatly undermines the pursuit of gender equality. Twenty years into the democracy and still an average woman in the province is not safe. More than a third of women who participated in the study reported that they have experienced GBV at least once in their lifetime. Shockingly, most of the violence is happening behind closed doors - a place called home, where they are supposed to be protected.

Forty-four percent of women interviewed experienced abuse from an intimate partner at least once in their lifetime. Just over one tenth (12%) experienced violence from a partner over the last year. In the streets and public places, women are being harassed and raped. Seven percent of women interviewed experienced rape at the hands of a stranger. Interesting in this study, men are confirming that, yes, they are abusing women. Fifteen percent of men interviewed confirmed they had raped a woman at least once in their lifetime. Thirty-seven percent have abused their partners.

These figures show that GBV has become a pervasive scourge of our modern society. Victims, predominantly women, come from poor to affluent communities across geographic, race, ethnic and economic divides. This shows that GBV cuts across all socio-economic and demographic classes. Every woman is at risk. The role of alcohol abuse in exacerbating gender violence in the Western Cape cannot be overemphasised. Alcohol has been, and remains, a problem in the Western Cape which fuels many social vices that characterise the province. Findings from national household surveys reflect higher prevalence rates for risky drinking relative to the other provinces. Research also shows that alcohol and substance abuse has immensely contributed to dysfunctional families in the Western Cape. Broken families provide a breeding ground for abuse. Child abuse is rampant in the province, thus contributing to the cyclical nature of GBV.

The findings from this study call for a holistic solution to seriously address the problem of GBV. South Africa should be commended for the efforts it is making in responding to GBV: the progressive and comprehensive legislation; the establishment of the National Council against GBV (NCGBV) as co-ordinating board, and other response structures such as the Thuthuzela Care Centres. Currently, the NCGBV is co-ordinating the development of the National Strategic Plan to end GBV, a tool we all believe is very important for the country. At provincial level, we welcome the government initiatives such as the Western Cape Integrated Violence Prevention Frame work of 2013 as well as the Violence Prevention through Urban Upgrading (VPUU). We also have networks such as the Network against GBV that is co-ordinating interventions to address GBV at local levels. However, given the high levels of GBV it is evident that there is need for upscaling our efforts. Are our leaders doing enough to bring the much needed change? Are the policies addressing the patriarchal culture which perpetually reduces women to mere 'properties' owned by their male counterparts? Are enough resources being availed to support survivors of violence?

This report is unique in that it employs a multi-dimensional approach. It seeks to answer all the questions presented here. The attitude survey clearly shows that GBV is deeply entrenched in the patriarchal ideologies that perpetuate the subordination of women. The political discourse shows that the leaders need to upscale their commitment towards the eradication of this epidemic. Thus, the province needs to adopt a multisectoral approach in addressing GBV. The solution needs to bring together all relevant stakeholders in concerted efforts. The solution also needs to address the root causes of GBV as this report has identified them. This includes the reduction of harmful drug and alcohol use as well as eradication of child abuse. Working with men, traditional leaders, religious leaders and the education sector is of paramount importance.

I welcome this study and want to commend Gender Links and partners for the sterling work they are doing. I now call upon all the relevant stakeholders who are in this fight to use the findings from this report.

Executive Summary

Inspired by the SADC Protocol on Gender and Development, which aims to halve GBV by 2015, this study, is the fourth stand-alone, provincially representative and comprehensive community-based research study of its kind. It looked at the prevalence of gender violence in the Western Cape province of South Africa. It measured violence against women (VAW) experience and perpetration, gender attitudes, selected health-related behaviour and exposure to prevention campaigns among women and men in Western Cape. The study also looked at intimate partner violence (IPV) including physical, sexual and emotional violence, non-partner rape and sexual harassment. It presents findings in five categories: the extent; drivers and patterns; effects; responses; support and prevention of VAW.

Children of Joe Slovo informal settlement in Mossel Bay. *Photo: Ntombentsha Mbadlanyana*

Thirty-nine percent of women experienced some form of gender-based violence in their lifetime including intimate partner and non-partner violence. The same (39%) proportion of men had perpetuated GBV in their lifetime.

Most of the violence occurred within intimate relationships and was predominantly emotional, a form of GBV not usually addressed. Forty-four percent of ever partnered women experienced IPV while 37% of ever partnered men reported perpetration of some form of IPV in their lifetime. Forty percent of the women experienced emotional violence while a third of men perpetrated the same form of violence in their lifetime. Women experienced, and men perpetrated, other forms of intimate violence including physical, sexual and economic violence. A quarter of women and 20% of men reported physical IPV experience and perpetration respectively. Thirteen percent of women and 9% of men reported economic IPV experience and perpetration respectively. Thirteen percent of women experienced, and 5% of men perpetrated, sexual IPV.

Thirteen percent of ever pregnant women reported abuse during at least one of their pregnancies. In the majority of cases, women and men reported multiple incidents of physical or sexual IPV.

More than a tenth (12%) of women experienced and men perpetrated some form of IPV in the 12 months before the survey. Similar to the lifetime prevalence trends, emotional IPV was the most common form reported by both women and men (9%). Six percent of women experienced and 4% of men perpetrated physical IPV in the 12 months before the survey. Six percent and four percent of women experienced economic and sexual IPV respectively. Three percent of men perpetrated economic and sexual IPV in the 12 months before the survey. One percent of women experienced rape by non-partners in their lifetime while 2% of men admitted perpetration of non-partner rape.

Although statistics show that VAW is rife in Western Cape, the majority of women survivors do not report

violence to the police or seek help from health care facilities. Only 1% of women who experienced physical abuse or threats by partners reported the incident to the police, while 2% of the women reported the physical abuse and injuries to medical providers. Generally, the findings revealed an underreporting by women of violence. As such, there is an urgent need to explore factors that hinder women from reporting.

The study has shown significant associations between various individual, relationship, community and societal factors and VAW experience and perpetration. Socio-demographic factors, cultural norms that uphold male dominance and control over women, wife "ownership", sexual entitlement in marriage, men's experience of sexual abuse as children, and alcohol and substance abuse, all exacerbate the incidence of VAW in the Western Cape.

VAW has negative effects on women's health and wellbeing. These effects include physical injury, poor mental health, unplanned pregnancies, stigmatisation, loss of days from work, sexually transmitted infections (STIs) and increased risk to HIV as well as out-of-pocket expenses. Since women constitute a higher proportion of GBV survivors they also bear the higher costs among the survivors.

In response to its high levels of GBV, South Africa has implemented progressive and comprehensive laws, policies and support systems to respond to VAW. Some regional and international instruments adopted by the country include the Convention for the Elimination of Discrimination Against Women (CEDAW), the SADC Declaration on Gender and Development, and the United Nations Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power. These instruments have been localised, giving rise to the Domestic Violence Act (DVA), Sexual Offences Act (SOA), Employment Equity Act, Service Charter and Minimum Standards on Services for Victims of Crime, and the National Policy Guidelines for Victim Empowerment, all of which work towards the elimination of VAW in the country. Despite the legislation, significant proportions of women and men are not aware of these laws. Thirty-eight percent of women and 28% of the men were not aware of the DVA. More than half (60%) of the women and 38% of men were not knowledgeable about the SOA. Women in the province seem to have more access to information about activism campaigns compared to men.

The national Victim Empowerment Programme (VEP) has facilitated the establishment and integration of intersectoral programmes and policies for the support, protection and empowerment of victims of crime and violence, with special focus on women and children. The South African Police Service (SAPS) has estab-lished VEP centres in police stations across the Western Cape Province. There is a shortage of first-stage shelters for abused women. Even fewer second- and third-stage shelters exist, leaving women seeking refuge after first-stage shelter with nowhere to go. The adverse economic conditions faced by many women in the province exacerbate the situation. A woman leaving a shelter often has few, if any, options other than to go back into an abusive relationship.

Several integrated approaches exist that involve both government and civil society in dealing with the prevalence of GBV at national and provincial levels. These include the NCGBV, the 365 Day National Action Plan to End Violence Against Women and Children (NAP), the Integrated Victim Empowerment Policy (IVEP) and the Thuthuzela Care Centres (TCCs). Despite these structures, incidence of GBV remains widespread and many survivors do not access TCCs or the one-stop centres that form part of the VEP programme. Western Cape government has adopted the Provincial Integrated Violence Prevention Policy Framework which employs the "whole-of-society" approach in preventing violence.

Challenges in the operationalisation of integrated structures and policies include lack of funding for the structures, poor co-ordination among structure members and poor monitoring and evaluation systems. Other issues include the inadequacy and ineffectiveness of some of the structures, including the TCCs, which refer less than half of the cases to the courts. This can act as a deterrent for survivors who access these services. National conviction rates for sexual offences have also decreased.

Table I: Extent of GBV in the Western Cape				
Criteria	**Prevalence of GBV in the survey**			
	Women's experience in a lifetime (%)	Men's perpetration in a lifetime (%)	Women's experience in the past year (%)	Men's perpetration in the past year (%)
Prevalence of GBV	39	39	-	-
Prevalence of IPV	44	37	12	12
Prevalence of emotional IPV	40	30	9	9
Prevalence of physical IPV	25	20	6	4
Prevalence of economic violence	13	9	6	3
Prevalence of sexual violence	13	5	4	3
Prevalence of non-partner rape	7	15	1	2
Prevalence of attempted rape	8	10	1	3
Prevalence of abuse in pregnancy	13	-	-	-
Prevalence of sexual harassment	6	-	-	-
Prevalence of sexual harassment at school	1	-	-	-
Prevalence of sexual harassment at work	5	-	-	-

Table I shows:

- Thirty-nine percent of women experienced some form of GBV, and the same (39%) proportion of men had perpetuated GBV in their lifetime;
- IPV is the most common form of GBV experienced by women, with 44% of women having experienced it in their lifetime and 12% in the 12 months prior to the study;
- Emotional abuse is the most common form of IPV experienced and perpetrated, followed by physical, economic and sexual abuse respectively;
- Six percent of women experienced physical violence in the year prior to the survey;
- Thirteen percent of women experienced some form of abuse during pregnancy;
- Six percent of women had experienced sexual harassment in their lifetime;
- In most indicators, men admitted perpetrating violence less often than women admitted experiencing violence.

Drivers and patterns of GBV

This study used the ecological framework (Heise, 1998) to illustrate risk factors of experience and perpetration of IPV. It explored individual, community and societal factors associated with experience and perpetration.

Individual factors

Table II: Socio-economic factors associated with experience and perpetration of IPV								
Factors	**Ever IPV**				**Past 12 months IPV**			
	% women survivors	Chi(p)	% men perpetrating	Chi(p)	% women survivors	Chi(p)	% men perpetrating	Chi(p)
Age								
18-29	44.7	0.19	41.4	0.26	17.6	0.002	19.9	0.0002
30-44	46.9		36.9		15.3		10.8	
45+	38.7		31.4		4.6		3.5	
Level of education								
High school incomplete and lower	47.6	0.17	42.4	0.02	13.1	0.47	13.8	0.31
High school complete and over	39.9		32.2		10.7		10.1	
Worked in past 12 months								
No	43.2	0.87	39.1	0.39	10.4	0.17	13.1	0.21
Yes	43.9		35.0		13.6		10.5	

Table II shows:

- Age, level of education and employment status were not associated with IPV among women in GBV experiences in lifetime. This implies that all women remain vulnerable to IPV;
- There was a significant difference in men's perpetration of IPV according to age and in the 12 months prior to the study;
- A statistically significant proportion ($p<0.05$) of men who did not complete high school, perpetrated IPV in their lifetime compared to men who did complete high school.

Rape

There was no statistical difference in the proportion of women raped by a non-partner according to age, level of education and employment status both in lifetime experiences and in the 12 months prior to the survey;

A significantly higher proportion of men who worked 12 months prior the survey admitted raping a non-partner ($p=0.02$).

Childhood abuse

The study explored whether experience of childhood abuse is associated with IPV and rape perpetration by men. The childhood experiences of both women and men who took part in the study showed that more men than women experienced the various forms childhood abuse. A higher proportion of men (80%) and about half (49%) of women experienced physical abuse in childhood.

Table III: Childhood abuse as a risk factor of perpetration of IPV				
Factors	**IPV**		**Non-partner rape**	
	% men perpetrating	p value	% men perpetrating	p value
Childhood physical abuse				
No	22.0	0.003	7.3	0.02
Yes	40.0		17.4	
Childhood sexual abuse				
No	31.0	0.0001	8.1	0.000
Yes	55.0		41.0	
Childhood neglect				
No	27.0	0.000	10.4	0.01
Yes	45.0		19.2	

Table III shows:

- All forms of childhood physical abuse were significantly associated with perpetration of both IPV and non-partner rape ($p<0.05$);
- Two fifths (40%) of men who had been physically abused as children reported perpetrating IPV whereas 22% of men who did not experience physical abuse committed IPV;
- Slightly less than half of men who had been victims of childhood neglect (45%) committed IPV compared to those who had not suffered neglect (27%);
- A higher proportion (55%) of male survivors of childhood sexual abuse perpetrated non-partner rape compared to non-survivors;
- Nearly a fifth (19%) of survivors of childhood neglect perpetrated non-partner rape while 10% of non-sufferers of child neglect admitted the same offense;
- Forty-one percent of male survivors of childhood sexual abuse committed non-partner rape whereas 8% of non-sufferers of childhood sexual abuse still committed non-partner rape.

Alcohol and drug use

Alcohol and drug use was associated with IPV perpetration in the 12 months preceding the survey; and About one fifth (19%) of male drug users and 8% of non-drug users perpetrated IPV in the 12 months prior to the survey.

Relationship factors

Generally, the attitudes that support gendered masculinity and patriarchy increased the risk of VAW.

Community factors

Table IV: Personal gender attitudes		
	Women strongly agree %	Men strongly agree %
Gender relations		
I think a woman should obey her husband	70	90
I think people should be treated the same whether they are male or female	80	94
I think that a man should have the final say in all family matters	25	67
I think a woman needs her husband's permission to do paid work.	13	25
I think that there is nothing a woman can do if her husband wants to have girlfriends	13	14

	Women strongly agree %	Men strongly agree %
Sexual entitlement		
I think it is possible for a woman to be raped by her husband	48	64
I think that if a man has paid lobola for his wife, he owns her	8	42
I think that a woman cannot refuse to have sex with her husband.	17	39
I think that if a wife does something wrong her husband has the right to punish her	8	27
I think that if a man has paid lobola for his wife, she must have sex when he wants it	6	34

Table IV shows:

- High proportions of women (70%) and men (90%) agreed that a woman should obey her husband;
- High proportions of women (80%) and men (94%) felt that people should be treated the same despite their gender;
- Greater proportions of men than women thought that a husband has sexual entitlement;
- Eight percent of women and 42% of men agreed that if a man paid lobola, he owns his wife;
- Eight percent of women and 27% men believed a husband has the right to punish his wife if she does something wrong.

Societal factors

Political environment

Table V: Political leadership	
Criteria	**%**
Percentage of GBV speeches by politicians that mention GBV (April 2010-March 2011)	7
Percentage of GBV speeches by politicians that refer to GBV as main topic	6
Percentage of GBV speeches by politicians that refer to physical abuse	51
Percentage of GBV speeches by politicians that refer to sexual offences	43
Percentage of GBV speeches by politicians that refer to domestic violence	31.4
Percentage of GBV speeches by politicians that refer to economic abuse	22.9
Percentage of GBV speeches by politicians that refer to femicide	11.1
Percentage of GBV speeches by politicians that refer to the link between GBV and HIV	10.5
Percentage of GBV speeches by politicians that refer to emotional abuse	5.9

Table V shows:

- Of the 2 238 speeches issued from April 2010 to March 2011, only 7% referred to GBV;
- The most mentioned form of GBV was physical abuse (51%), while the least discussed was emotional abuse (6%);
- Political leaders mentioned domestic violence in 31% of the speeches referring to GBV;
- Eleven percent of the speeches referring to GBV addressed the link between HIV and GBV.

Effects of GBV

Table VI: Effects of GBV	
Criteria	**% women**
Physical injury	
Percentage of physically abused women who sustained injuries	28
Percentage of physically injured women who spent days in bed because of injuries	59
Percentage of physically injured women who missed work as a result of injuries	45
Sexual and reproductive health	
Percentage of women who had been sexually abused by intimate partners and diagnosed with an STI	47
Percentage of women who had been physically abused by intimate partners and diagnosed with an STI	32
Percentage of women who had been raped by non-partners and diagnosed with an STI	41
Percentage of women who had been physically or sexually abused by intimate partners and tested HIV positive	13
Percentage of women who had been raped by non-partners and tested HIV positive	29
Poor mental health	
Percentage of women who had been abused by intimate partner and suffered depression	54
Percentage of women who had been raped by non-partner and suffered depression	41
Percentage of women who had been abused by intimate partners and attempted suicide	46
Percentage of women who had been raped by non-partners and attempted suicide	29

Table VI shows:

Physical injury

- Twenty-eight percent of women in the survey who had experienced physical abuse sustained injuries;
- A significantly high proportion (59%) of the women who experienced physical abuse sustained serious injuries and had been bedridden.

Reproductive health effects

- Almost half of the women (47%) who had suffered sexual abuse from an intimate partner had contracted an STI;
- Thirty-two percent of women who had experienced physical abuse reported having been diagnosed with STIs;
- Forty-one percent of women who had been raped by a non-partner in their lifetime had been diagnosed with an STI;
- Thirteen percent of women who experienced physical or sexual abuse by an intimate partner tested HIV positive.

Mental health effects

- A significant proportion (54%) of IPV survivors and two fifths (41%) of non-partner rape survivors had suffered from depression;
- Forty-six percent of IPV survivors attempted suicide;
- Nearly a third (29%) of women raped by non-partners attempted suicide.

Costs of GBV

Due to bureaucratic constraints and poor recording systems, it is difficult to access data on the accurate amounts of money spent on GBV. Data derived from the Department of Justice and Constitutional Development shows that the estimated cost of running a Thuthuzela Care Centre in the Western Cape is R4 089 312 per annum.

Response and support

Table VII: Response and support indicators

Criteria	% women	% men
Awareness of legislation		
Proportion of participants aware of the Domestic Violence Act	62	72
Proportion of participants aware of the Sexual Offences Act	40	62
Proportion of participants aware of protection orders (POs)	78	75
South African Police Service (SAPS)		
Number of rape cases recorded by SAPS in 2011/2012	5 969	
Number of sexual assault cases recorded by SAPS 2011/2012	2 005	
Number of sexual offences detected by police 2011/2012	236	
Number of other contact sexual crimes recorded by SAPS 2011/2012	513	
Number of attempted sexual offences recorded by SAPS 2011/2012	410	
Number of interim protection orders granted in 2011	217 987	
Number of final protection orders granted in 2011	87 711	
Number of Family Violence, Child Protection and Sexual Offences Units (FCSs)	25	
Number of Victim Friendly Rooms (VFCs)	150	
Number of final protection orders granted in 2011	87 711	
Number of interim protection orders in 2011	217 987	
Shelters and counselling services		
Number of new cases received at Saartjie Baartman Centre	739	
Number of new cases received at St Anne's Home and Place of Safety 2011-2012	61	

Table VII shows:

Awareness of laws

- More men (72%) than women (62%) are aware of the Domestic Violence Act;
- About two fifths (40%) women and 62% men interviewed knew about the Sexual Offences Act;
- Seventy-eight percent women and 75% of men had heard about protection orders.

South African Police Services

- The SAPS recorded 5 969 rape cases, 2 005 sexual assault cases and 410 attempted sexual assault cases in 2011/2012.
- The SAPS created 25 FCS units in the Western Cape. These offer specialised services to deal with domestic violence at police stations.
- About 150 Victim Friendly Rooms exist in the Western Cape. The VFCs offer private and comfortable environments for survivors to be informed about their rights following a case of GBV.
- There was a significant variation in interim POs and final POs granted in 2011.
- For the year 2011, police granted 217 987 interim POs and 87 711 final POs.

Prevention

Table VIII: Prevention indicators		
Criteria	**% women**	**% men**
Proportion of participants who had heard of the 16 Days of Activism campaign in the 12 months prior to the survey	83	78
Proportion of participants who had heard of the 365 Days campaign in the 12 months prior to the survey	83	54
Proportion of participants who had ever participated in a march or event in protest against GBV	27	22
Proportion of participants who had accessed information about GBV from a radio programme	32	49
Proportion of participants who had accessed information about GBV from a television programme	38	16
Proportion of participants who had accessed information about GBV from newspapers	10	25

Table VIII shows:

- A higher proportion (83%) of women compared with 78% of men had heard about the 16 Days of Activism campaign in the 12 months prior to the survey;
- Eighty-three percent of women and 54% of men had heard about the 365 Days campaign;
- Less than a third (27%) of women and 18% of men had participated in a march or event in protest against GBV;
- Thirty-eight percent of women and 16% of men had received information about GBV from a television programme;
- More men (25%) than women (10%) received information about GBV from a newspaper;
- Compared to other provinces studied, women and men in the Western Cape (and women more so than men) are more aware of campaigns and legislation to protect women and children.

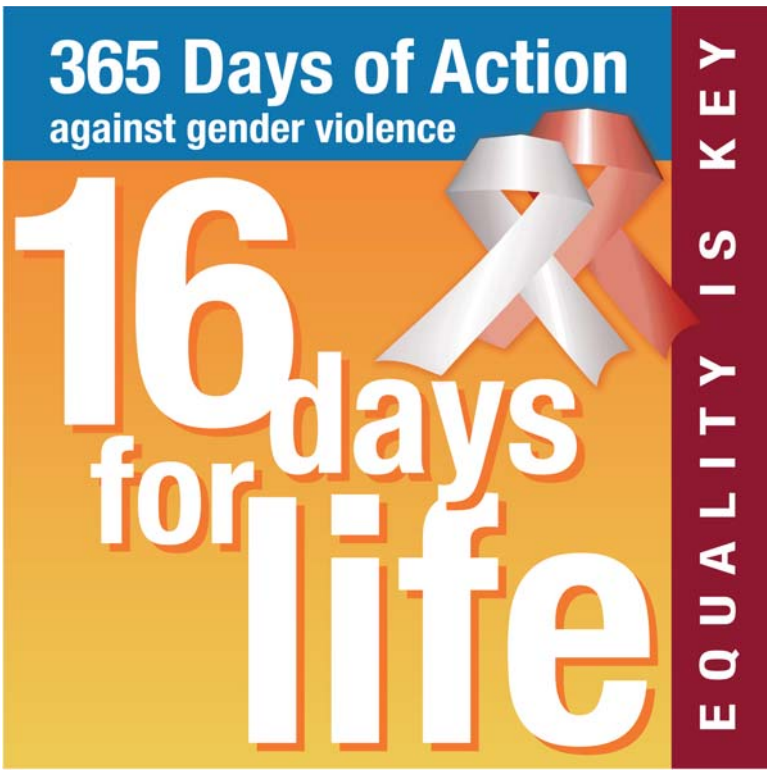

Table IX: Conclusion and recommendation	
Conclusions	**Recommendations**
Extent	
Western Cape like KwaZulu-Natal (KZN), Limpopo and Gauteng exhibits high prevalence rates of GBV. Emotional IPV is the highest form of GBV experienced by women and perpetrated by men both in their lifetime and in the 12 months before the survey.	There is a need to focus on prevention strategies that seek to address the root causes of violence in both the public and private domains. There is a need to educate the community to treat violence against women, especially IPV, as a major social problem. The community and individuals need vigorous encouragement to change the attitudes that promote a culture of silence. There is also need for stiffer penalties for perpetrators of GBV.
The study shows high levels of underreporting of GBV in the province. The majority of women who experienced IPV or non-partner violence are less likely to report abuse to the police and health care providers.	There is a need to explore further the factors that promote underreporting of violence. Appropriate interventions such as improvements in service provision by the police and health care providers are necessary. These should emphasise both quality as well as quantity. Mechanisms aimed at reducing the danger of community stigmatisation are essential. There is need to empower women to demand their rights and be able to speak out about their experiences of abuse in the public and private domains.
Drivers and patterns	
Perpetration of IPV in a lifetime is inversely associated with education. Perpetration of IPV in the past 12 months significantly decreased with an increase in age. For women, experience of IPV in their lifetime was not significantly associated with age, education and employment implying all women are at an equal risk regardless of their socio-demographic factors.	It is important to promote awareness training especially to sensitise and educate young men against GBV. There is great need to eradicate patriarchal gender attitudes that promote inequality and the subordination of women by men in intimate relationships.
Experience of childhood abuse influences the perpetration of IPV by men. Similarly, childhood neglect and sexual abuse increase the risk of men perpetrating non-partner rape.	There is need to develop strict control measures particularly in the area of corporal punishment which is taking place illegally behind closed doors in homes and in schools. It is critical to prevent all forms of child abuse. There is need for abuse screening in schools as well as to provide rehabilitation services to abused children.

Conclusions	Recommendations
Alcohol and drug abuse is rampant in the province and this triggers violence thereby increasing the risk of IPV perpetration. The government passed the Western Cape Liquor Act of 2009 which came into effect from April 2012 which regulates liquor outlets and aims to limit access to alcohol in residential areas.	There is need to intensify health promotions that discourage the unwarranted use of alcohol. There is need to revise the current legal drinking age and to introduce a minimum liquor purchasing age. There is need for government to take on alcohol abuse as a national priority. Government can do this by introducing and sustaining more severe penalties for excessive drinking.
There are relatively few mentions of GBV by government in public discourse. Furthermore, the speeches imply that government does not sufficiently understand the problems associated with GBV in the country.	There is need for politicians to champion the fight against GBV. It is crucial that politicians make regular public pronouncements informed by an understanding of the forms and nature of violence.
Effects	
Evidence shows that women who experience IPV are prone to physical injury, poor mental health and increased risk of HIV and STIs. GBV ultimately results in death or disability.	There is a need for the health sector to be responsive to current World Health Organisation clinical and policy guidelines on IPV and sexual violence. Also crucial is the need for prompt screening of GBV survivors to ensure improved access to appropriate medical care. Government should take the lead in prioritising mental health by providing adequate funding, appropriate infrastructure and human capital to psychiatric and mental health services. There is need for a holistic approach that engages the media, health services, policy makers and social services in responding to, as well as preventing, GBV.
Response and support	
Government has taken significant strides by establishing structures that seek to focus on the victims of GBV. The major departments mandated to assist survivors of violence are the police, justice, social services and health. Evidence shows that the provision of shelters and economic empowerment are ways to improve survivorship of GBV. There are few shelters in the Western Cape that offer support to survivors of GBV.	There is need for constant monitoring and evaluation of the policies relating to violence to ensure the adoption of effective prevention and response mechanisms in the province. It is important for government to increase funding to existing shelters, victim friendly rooms (VFRs), and other GBV-related initiatives in the Western Cape, including establishing new places of safety.

Conclusions	Recommendations
Prevention	
Factors that increase the risk of violence are multifaceted in nature. These often include the need to perpetuate conservative individual and community attitudes on gender equality, alcohol and drug abuse, child abuse and socio-economic factors such as age and education.	There is need for government and civil society to undertake a paradigm shift from a responsive perspective to a more proactive shift in addressing all factors influencing violence in the society. There is need to place more emphasis on mobilising communities especially in rural areas, to challenge gendered ideas of masculinity. It is critical to implement secondary and tertiary interventions that prevent recurring acts of perpetration.
It is commendable that in the Western Cape, the majority of women were aware of prevention campaigns and laws and that they proved to be more knowledgeable compared to men. In the other provinces, men were more knowledgeable than women.	There is need to strengthen the strategies which encourage women to participate in the campaigns relating to GBV. It is critical to sensitise men so that they also participate in campaigns and marches, and not only to know the laws that protect women but to embrace and uphold them in order to prevent further perpetration of VAW.
Strong and sustained political will and commitment is critical in the implementation of violence prevention strategies. The government allocated about R16 million towards GBV in 2013/2014. Western Cape government developed the provincial integrated violence prevention policy framework which employs the "whole-of-society" approach in preventing violence.	It is critical for government to avail sufficient resources for ending GBV.
Integrated approaches	
The government of South Africa has done well in coming up with policies and structures that seek to protect women compared to other countries in the region. It has made significant strides in drawing up plans such as the 365 Day NAP, the National Council against GBV and the Integrated Victim Empowerment Policy among others. Nevertheless, these plans fall short when it comes to full implementation because of lack of adequate funding, poor planning, lack of coordination, accountability and capacity, and confusion as to demarcation of responsibilities among stakeholders.	There is need to adequately fund the implementation of the action plans and other initiatives related to ending GBV. There is need to use best practices in educating, and increasing capacity of the personnel involved in the planning, coordination and successful implementation of action plans on GBV. It is critical for government to develop a dedicated monitoring and evaluation framework that is utilised by organising committees of the various action plans.