United States Government

Gender-Based Violence Assessment Report

South Africa

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Key Definitions

- ***Sex*** refers to the biological characteristics which define individuals as female or male.
- ***Gender*** refers to the attributes, constraints and opportunities associated with being a man and a woman. It also refers to the array of socially-constructed roles and relationships, personality traits, attitudes, behaviors, values, relative power and influence that society ascribes to the sexes on a differential basis.
- ***Gender-based violence*** refers to violence that is directed at an individual based on his or her biological sex, gender identity, or perceived adherence to socially-defined norms of masculinity and femininity. It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private life.

  Gender-based violence (GBV) takes on many forms and can occur throughout the lifecycle, from the prenatal phase through childhood and adolescence, the reproductive years, and old age. Types of GBV include female infanticide; harmful traditional practices such as early and forced marriage, "honor" killings, and female genital cutting; child sexual abuse and slavery; trafficking in persons; sexual coercion and abuse; neglect; domestic violence; and elder abuse.

  Women and girls are the most at-risk and most affected by GBV. Consequently, the terms "violence against women" and "gender-based violence" are often used interchangeably. However, sexual and gender minorities, such as men who have sex with men and transgendered persons are also subjected to GBV. Regardless of the target, GBV is rooted in structural inequalities between men and women and is characterized by the use and abuse of both physical, emotional, and/or financial power and control.
- ***Gender equality*** entails the concept that all human beings, both men and women, are free to develop their personal abilities and make choices without the limitations set by stereotypes, rigid gender roles, or prejudices. Gender equality connotes equal access to resources and services.
- ***Gender equity*** connotes fairness in the distribution of opportunities and benefits. Equity is the means, and equality is the result.[1]

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I. Executive Summary

The United States Government (USG) South Africa country team convened a Gender-Based Violence (GBV) Assessment Team to conduct an assessment of South African GBV programs and priorities; understand how the USG can address gaps and challenges in the current response, and provide recommendations to inform future USG decision-making about GBV programming in South Africa.

The GBV Assessment Team met with over 60 South African organizations, government departments and donors; and conducted site visits to GBV facilities over the course of two weeks (31 Jan – 11 February, 2011) in three Provinces, namely Gauteng, KwaZulu Natal (KZN) and Western Cape.

This report highlights the overall GBV situation in South Africa, describes the efforts of a sample of key stakeholders in government and civil society who are leading prevention and treatment efforts, identifies challenges and gaps in both GBV services and prevention, and makes recommendations by which USG can enhance its efforts to facilitate coordination, improve GBV prevention programming, and strengthen existing GBV services.

South Africa has among the highest rates of gender-based violence in the world.[1] According to the South African Police Service, more than 55,097 rapes were reported to the police in 2009/10.[2] However, according to research by the Medical Research Council in 2009, only 1 in 25 rapes is reported annually.[3] Half of all female homicides in South Africa are committed by an intimate partner, and the rate of female homicide by an intimate partner is six times the global average.[4] Young people are particularly prone to experiencing and perpetrating sexual violence: 60% of survivors presenting at Thuthuzela Care Centers (TCCs) are under 18, and 40% of the survivors are under 12.[5] Research published in the Lancet showed that in South Africa, intimate partner violence and high levels of male control in a woman's current relationship were associated with HIV seropositivity.[6] In fact, an estimated 16% of all HIV infections in women could be prevented if women did not experience violence from their partners.[7]

Overall the South African Government (SAG) recognizes the magnitude of GBV, and makes a significant commitment to programs that address and prevent its occurrence. To date, SAG has made dramatic improvements in the prosecution of offenders and provision of services to victims.

The Department of Justice and Constitutional Development is currently taking the lead in SAG's GBV efforts, through the Sexual Offences and Community Affairs Unit, in charge of running the TCCs for survivors of sexual assault (40 of 52 centers were established or upgraded with USG funds beginning in 2006, and additional centers were funded by UNICEF). TCCs provide a wide range of rape care services under one roof by specially trained staff, with the goal of providing care for the survivor in a way that reduces secondary victimization and builds a case ready for successful prosecution.

The Department of Social Development is also leading GBV efforts through its Victim Empowerment Program providing similar services at One-Stop Centers in high GBV prevalence areas, with an additional focus on shelters and psychosocial support services.

The new ministry, the Department of Women, Children and Persons with Disabilities, hopes to take a leading role in SAG's GBV efforts by coordinating its internal GBV mechanism, the Inter-Departmental Management Team, and its arm for collaboration with civil society organizations (CSOs), the National

Gender Machinery. It also hopes to pass a new Gender Equity Bill, which will address gaps in current legislation such as hate crimes based on sexual orientation, or human trafficking.

South Africa's vibrant civil society sector is implementing numerous campaigns and providing sophisticated GBV services in many areas. USG supports Brothers for Life, for example, a national campaign aimed at changing male norms around the treatment of women, condom use, HIV testing, and involvement in parenting. It has mobilized hundreds of partners to spread its message through community dialogues, television dramas known as "soapies", radio talk shows, billboards and other forms of media. USG also supports The Greater Nelspruit Rape Intervention Project, which provides an example of high-quality services for rape survivors of all ages, using a victim-centered approach that builds upon local networks and mobilizes volunteers to provide long-term follow up.

Numerous progressive and comprehensive legal frameworks, both at national and international levels have been created that pertain to GBV, on prevention, provision of care, prosecution of offenders, addressing domestic violence, GBV in schools, HIV/AIDS, child protection and more. However, efforts to implement this legislation have not always kept pace and several gaps and challenges remain.

Data on the magnitude of South Africa's GBV challenge are poor: no national studies have been conducted and official police data are difficult to interpret. Secondary victimization by poorly trained police, health care providers and other service providers in the criminal justice system can create a significant deterrent from reporting incidences of GBV. Despite dramatic improvements in prosecution rates due to the TCCs and other models, areas without these services have difficulty prosecuting perpetrators and protecting survivors from further violence and abuse.

While the TCC blueprint for GBV services is comprehensive, GBV services are not uniformly high-quality, and survivors in many areas (especially rural, remote locales) do not have access to facilities and services. In particular, after-hours care and the provision of psychosocial support are insufficient. Moreover, awareness of the existence of TCCs and the services they provide is very low, both among communities that are in need of their services, and among service providers who could provide referrals (such as the police). To address these challenges, TCCs must be supported to increase awareness of services, encourage their utilization, and to better engage with civil society partners with track records of providing comprehensive services to survivors.

The assessment team noted increased interest in GBV prevention amongst SAG and civil society and looked at ways to expand and improve USG's programming in this area. Prevention programs have not always addressed the causes of GBV in South Africa, such as patriarchal norms. Some interventions stop at awareness-raising, or only encouraging people to report instances of abuse, instead of engaging people in relevant ways that encourage positive behavior change.

The complex nature of GBV requires a multi-faceted response at various levels. As such, the focus of USG-supported GBV programming should support national and provincial coordination, prevention and services. The recommendations for action reflect areas that fall within the purview and manageable interest of USG/South Africa (SA), address needs identified through the assessment, and contribute to focus areas and priorities of SAG and civil society.

Based on the GBV team's assessment of the current situation, key gaps, and the relative level of effort to date in each area, the team recommends that the USG portfolio devote roughly 60% of the total budget to prevention programming; 30% to services, both medical and those related to legal and judicial support; and 10% to national and provincial coordination and policy implementation. Furthermore, USG should support

efforts to understand the magnitude of GBV in South Africa and the populations most affected through scientifically rigorous research. USG has invested significantly in GBV services and prevention programming and should focus on strengthening existing initiatives before developing new ones.

In conclusion, the appointed USG South Africa country GBV dedicated personnel should work closely with the SAG to support their coordination of GBV activities. There should be ongoing communication to share information and promising practices to strengthen the SA GBV interventions and initiatives. Coordination amongst all the relevant stakeholders will prevent overlaps in GBV program implementation and lead to efficient use of available resources.

II. Scope of work

PEPFAR considers GBV a high priority. The 2009 – 2013 Reauthorization legislation calls for "working to eliminate rape, gender-based violence, sexual assault, and the sexual exploitation of women and children." PEPFAR named "reducing violence and coercion" as one of its five gender strategies. In South Africa, the USG supports a range of activities to address GBV, of which PEPFAR funds a large portion. Currently, programs are not tied together by an overall strategic plan, nor do they a share an articulated long-term objective. While each program has strengths, there is not a clear understanding that this is the most effective or best-coordinated use of USG resources to fight GBV in this country. It is also not clear which programs represent better, or best, practices.

To address these gaps, the USG South Africa country team convened a GBV Assessment Team to conduct an assessment of current South African GBV programs and priorities and to provide recommendations to inform future USG decision-making about GBV programming in South Africa.

The team was comprised of:

- Diana Prieto, MPP. Senior Gender Advisor- USAID/Washington/Office of HIV/AIDS
- Joya Banerjee, MS. Gender Specialist- CDC/South Africa
- Natasha Greenberg, MA. Program Specialist- USAID/Washington/Office of Women in Development
- Olga Mashia. Youth and Prevention Specialist- USAID/South Africa
- Suzanne Leclerc-Madlala, PhD. Culture & Gender Advisor- USAID/Washington/Office of HIV/AIDS

The objectives of the assignment were to:

- Provide background and context on the incidence of GBV in South Africa;
- Describe South African Government (SAG) priorities and responses;
- Assess key interventions focused on prevention and treatment of GBV in South Africa;
- Identify gaps and challenges; and
- Advise on the role of the USG in addressing GBV in South Africa.

Methodology

The USG GBV Assessment Team met with over 60 South African organizations, government departments, donors and facilities over the course of two weeks (31 Jan – 11 February, 2011) in three Provinces, namely Gauteng, KwaZulu Natal and Western Cape. Research was conducted through site visits, interviews, a donor roundtable and a researchers' roundtable. The team also reviewed GBV literature provided by the USG South Africa country team and key informants. The findings and recommendations presented in this report are based in large part on information gleaned from the interviews and materials reviewed, and draw on promising practices to address GBV.

This report assesses the overall GBV situation in South Africa, the SAG response, current programming, gaps and challenges, and provides substantive recommendations in the areas of prevention; medical, social and legal services; research; and overall coordination.

Limitations

Given the magnitude of the problem as well as the breadth of GBV activities in South Africa, it was necessary to visit a wide range of stakeholders and programs. However, the time limitations of conducting the GBV assessment within 10 days constrained the ability of the GBV team to be as exhaustive as would have been ideal. Therefore, this report highlights only a sample of GBV interventions by USG-supported civil society partners and others, but is by no means exhaustive.

In terms of key SAG departments that address some facet of GBV, the team was not able to meet with the Department of Defense (DOD), Department of Correctional Services (DCS), South African National AIDS Council (SANAC), and Department of Education (DOE). The USG Gender Focal Person will pursue collaborating with these Departments as we plan to roll out and scale up gender programming in SA.

III. Overall GBV Situation in South Africa

Incidence of GBV

South Africa has among the highest rates of GBV in the world.[8] GBV manifests in various forms of sexual violence perpetrated against men and women by strangers or acquaintances or through intimate partner violence within the home. According to the South African Police Service, more than 55,097 rapes were reported to the police in 2009/10.[9] However, according research by the Medical Research Council in 2009, only 1 in 25 rapes is reported annually.[10]

Half of all female homicides in South Africa are committed by an intimate partner, and the rate of female homicide by intimate partner is six times the global average.[11] In KwaZulu Natal Province, 46% of sexually active young women reported coerced first sex, including being persuaded, tricked, physically forced, or raped.[12] In Gauteng Province, a recent study by Genderlinks and the Medical Research Council found that over half of women (51.2%) have experienced some form of violence (physical, sexual, emotional or economic[13]) and 78.3% of men admit to perpetrating some form of violence against women.[14] Moreover, GBV statistics are drastically underreported due to fears of stigmatization, failures of—and lack of faith in—the criminal justice system, secondary victimization by untrained or improperly trained rape service providers, and retributive violence by perpetrators or their families.

The historic manipulation of African communities and associated breakdown of family life and traditional social structures for inculcating sexual responsibility and sanctioning of adult bad behavior has played an immense role in catalyzing the country's extraordinarily high levels of GBV. Contributing factors to GBV include the multiple legacies of apartheid, high rates of alcohol abuse, intergenerational cycles of violence,

social dislocation, poverty and unemployment. Embedded patriarchal values and beliefs form the basis of a culture of male sexual entitlement reinforced through social institutions and cultural scripts for female acquiescence and male control, all juxtaposed against rapid changes in the public status and roles of women.

According to the Medical Research Council,[15] income inequality (measured by the Gini coefficient), low economic development and high levels of gender inequality are strong predictors of rates of violence across countries.[16] South Africa has the worst income inequality and the highest level of homicide found in a study of 63 countries.[17] Unemployment, particularly male youth unemployment, is a consistent correlate of homicide and assault.[18] Currently, 24% of South Africans are unemployed nationally, with an unemployment rate of 29% among black South Africans compared to 5.9% among white South Africans.[19]

GBV's links to HIV

In South Africa, GBV fuels the HIV epidemic, and women represent a disproportionate majority of new infections. Among females between the ages of 20-24 and 25-29, HIV prevalence is twice as high as males in the same age group, and one in three females is HIV positive.[20] Research published in the Lancet in 2004 showed that in South Africa, intimate partner violence and high levels of male control in a women's current relationship were associated with HIV seropositivity.[21] GBV contributes to the HIV epidemic through various pathways. Studies show that violent or controlling male partners often impose risky sexual practices on their female partners.[22] Additionally, women who are in abusive relationships are particularly at risk of exposure to HIV infection due to the threat of further violence, abandonment or loss of economic support if they attempt to negotiate safer sex or refuse sex.[23]

Women living with HIV often face an increased risk of GBV. Because they are often first in the relationship to test positive through pre-natal testing, they are then branded as the "spreaders" of the virus. Once their HIV-positive status is revealed or disclosed to their partners, women may face being physically abused, losing access to important economic resources, or the threat of being chased from their homes.[24] The inadequate number of shelters, especially shelters where women can bring their children, make the choice to leave an abusive partner extremely difficult, if not impossible.

Alcohol abuse is a major contributor to GBV in South Africa, home to one of the highest per capita alcohol consumption levels in the world.[25] Many fights, homicides and rapes occur under the influence of alcohol, which is a powerful catalyst for interpersonal and sexual violence, and high-risk sexual behavior. [26] Alcohol reduces anxiety about the consequences of one's actions, and causes disinhibition and decreased awareness of social norms of acceptable behavior.[27] Often times victims are rendered vulnerable by alcohol,[28] [29] and evidence shows that women with heavy episodic drinking patterns (>5 drinks/occasion) are more likely to experience sexual violence, incorrectly/inconsistently use condoms, and acquire an STI—including HIV.[30] Victims[1] of violence often abuse alcohol and other drugs in order to deal with the trauma they have experienced. However, their drinking makes it harder for them to escape from further violence in their lives.[31] Additionally, children are often left extremely vulnerable because of their parents' drinking problem**:** 15% of children report times in their lives when one or both parents were too drunk to care for them.[32]

Populations at risk of GBV

[1] The terms 'victim' and 'survivor' been used interchangeably in this report to reflect the shifting and multiple circumstances of those who have experienced rape.

Young people are particularly prone to experiencing and perpetrating sexual violence: 60% of survivors presenting at TCCs are under age 18, and 40% of the survivors are under age 12.[33] It is estimated that 42% of boys and 43% of girls will suffer some form of abuse before the age of 18.[34]According to SAPS, of 27,417 cases of sexual offences against children reported in 2009/2010, 60% affected children under sixteen years of age, and 29% affected children under 11 years old.[35] Perpetrators of sexual offences against young children are overwhelmingly relatives, friends, acquaintances or neighbors, suggesting that most abuse takes place in or nearby the home.[36]

Young people are not only survivors of GBV but also its perpetrators. Research by the Medical Research Council shows that rape mostly starts in the teenage years; three quarters of men who rape do it for the first time before the age of 20.[37]

GBV occurs not just among women and girls, but also among men and boys. Approximately one in 30 men (3.5%) has been raped by a man.[38] [39] Additionally, 3- 10% of survivors presenting for post-exposure prophylaxis (PEP) at Population Council-supported facilities after being raped were male.[40]

Lesbian, gay, bisexual, transgender and intersexed (LGBTI) South Africans are at high risk of experiencing sexual violence: "corrective rapes" are being reported in increasing frequency, where men gang rape a woman they perceive to be a lesbian. These rapists often claim they want to "fix" lesbians to make them "real women." Also, women who are suspected of infidelity are sometimes "streamlined" by their male sexual partners, who invite their friends to rape their female partner as a punishment.

Prior to the establishment of the TCCs by the National Prosecuting Authority (NPA), conviction rates hovered at a mere 7% for perpetrators of rape. Now the average conviction rate for survivors cared for in TCCs, who choose to open cases, is approximately 60%, representing a dramatic accomplishment.[41] Still, overall prosecution rates are low, and even convicted offenders are often released early on bail. As a result, the threat of prosecution is so far failing to provide deterrence, and victims often have little faith in the criminal justice system.[42]

IV. South African Government Response

With the transition to democracy in 1994, there was concern about women's representation across all levels of government, leading to the establishment of the National Gender Machinery (NGM). It was a platform on which government departments had a voice in Parliament to assist in drawing the national agenda for women. Also established were the Office on the Status of Women, in the President's office, and the Commission for Gender Equality, with offices throughout the various provinces.

Throughout the 1990's (post-1994), the Women's League of the ruling African National Congress and the NGM helped various government departments to establish their own gender units. In its early years, SAG faced difficulties in establishing robust service delivery and monitoring and evaluation systems. In addition, because many of the strong leaders in CSOs prior to 1994 were absorbed into government, weakening the CSO sector, insufficient capacity is still an issue and polarization at different levels impacts on the relationship between government and civil society.

Nevertheless, there is interest and increased commitment to responding to GBV from high levels within the SAG. Numerous legal frameworks, both national and international, exist that pertain to gender equality and

GBV, regarding its prevention, provision of care, and prosecution of offenders. Challenges in implementing these legal frameworks are discussed in Section 6: Gaps and Challenges.

International Legal Frameworks

As a signatory to many International Conventions, South Africa is expected to provide regular progress reports to International bodies on its efforts to reach the set targets and to address GBV as well to protect and promote the wellbeing of women and children. Each government department that is part of the Social Cluster is responsible to provide reports in its respective area.

The SAG has committed to realizing gender equality and women's empowerment through the adoption of various human rights instruments, including:

- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW);
- Cairo Declaration from the International Conference on Population and Development (ICPD) Report (Cairo, 1994);
- Beijing Declaration and Platform for Action from the 4th World Conference on Women (Beijing, 1995);
- 2001 UNGASS Declaration of Commitment on HIV/AIDS,
- UN Millennium Declaration (Goal 3: Promote Gender Equality and Empower Women, Goal 4: Reduce Child Mortality, Goal 5: Improve Maternal Health, and Goal 6: Combat HIV/AIDS, Malaria and other diseases);
- Southern African Development Community's (SADC) Protocol on Gender and Development that aims to half gender violence by 2015.[43]

South African Legal Frameworks and Strategic Plans

The South African response is guided by the following legislation and plans that address underlying factors, outcomes, and different components of GBV.

National Constitution

South Africa's Constitution (1994), widely regarded as one of the most progressive in the world, explicitly enshrines gender equality as a key principle, outlawing sexism and discrimination based on gender and sexual orientation.

Equality Act

The Equality Act (2000) prohibits unfair discrimination on the grounds of race, gender, sex, pregnancy, marital status, ethnic or social origin, color, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth. Hate speech, harassment and the publication and dissemination of information that unfairly discriminate are also prohibited. The Act specifically prohibits GBV as discrimination on the basis of gender.[44] Any South African has the right to present his or her case in front of an Equality Court; however, due to lack of widespread awareness of legislation, the courts are largely underutilized.

Sexual Offences Act

The Sexual Offences Act[45] (2007) repeals the common law offence of rape and replaces it with a new expanded statutory offence of rape, applicable to all forms of sexual penetration without consent, irrespective of the sex of the perpetrator or victim. The Act is meant to intensify South Africa's efforts to fight sexual crimes against all persons; especially, sexual offences being committed against vulnerable groups, including women, children and people with mental disabilities.

The Act establishes a Sexual Offenders Register to keep record of those who have been convicted of sexual offences against children or persons with mental disabilities. This will be a confidential record, accessed only by employers to prevent certain persons from gaining access to children or persons with mental disabilities in the course of their employment.

Children's Act

The Children's Act (2005, amended in 2007) establishes children's constitutional rights to:

- Family care, parental care or appropriate alternative care when removed from the family environment;
- Social services;
- Protection from maltreatment, neglect, abuse or degradation; and
- Have their best interests considered to be of paramount importance in every matter concerning the child.

The Act aims to promote well-being and prevent abuse or neglect, as well as to increase the options for children found to be in need of care and protection. These and other objectives are achieved through the provision of social services for children and families that include: crèches and early childhood development programs; prevention and early intervention programs (including home-based care for families affected by chronic illnesses such as HIV/AIDS, and child and family counseling); drop-in centers; protection services (identifying, reporting and supporting abused and vulnerable children); and child and youth care centers.

South Africa has put certain sections of the new Children's Act, which lowers the age of majority to 18 and allows those above 12 access to HIV testing and contraceptives into immediate effect. Health practitioners are required to report suspicious cases to a child protection organization, social worker, police officer or children's court, if they suspect abuse, neglect and exploitation of a child under 16.

Maintenance Act

The Maintenance Act (2003) establishes a legal duty for both parents to provide for the basic living expenses of his or her dependants including food, water, rent, electricity, clothes, medical expenses and school fees. All children, whether born in our outside of marriage, have a right to maintenance, and payments are proportional to income. If a parent does not pay maintenance, the person claiming payment (spouse, other parent, child him/herself) can contact district Maintenance Courts and Officers, who are authorized to garner wages and sell property in order to enforce payment.

Domestic Violence Act

The Domestic Violence Act (1998) affords the victims of domestic violence the maximum protection against domestic abuse and introduces punitive measures to discipline those who ignore the law. This Act enables any person who observes domestic violence to report abuse.

Employment Act

The Employment of Educators Act (1998, amended in 2000) specifically calls for the dismissal of teachers who are found to have engaged in serious misconduct, including "committing an act of sexual assault on a learner, student or other employee," and "having a sexual relationship with a learner of the school where he or she is employed."

Department of Health Gender Policy

The Department of Health Gender Policy (2002) includes equitable access, rights and opportunities to healthcare at all levels of the health system for women, men, girls and boys, and to expand women's leadership in South Africa's health system and that gender and related issues have been integrated into the HIV & AIDS and STI National Strategic Plan 2007-2011.[46] It focuses mainly on ensuring gender equity within the Department of Health. [47]

HIV & AIDS and STI National Strategic Plan 2007-2011

The "HIV & AIDS and STI Strategic Plan for South Africa, 2007-2011", referred to as the NSP, builds on national programs to address GBV and mainstream HIV and AIDS interventions with priority given to the rural poor, urban informal settlements, and marginalized groups (such as sex workers and men who have sex with men).

One of its main goals is to "focus on the human rights of women and girls, including those with disabilities, and mobilize society to stop gender-based violence and advanced equality in sexual relationships."

The NSP contains explicit objectives on gender and GBV, such as to:

- Accelerate programs to empower women and educate men and women on women's rights and human rights
- Support national efforts to strengthen social cohesion in communities and to support the institution of the family
- Develop a comprehensive package that promotes male sexual health and addresses gender
- Introduce programs to mitigate the impact of alcohol and substance abuse
- Introduce programs to address scripted gender identities that contribute to GBV
- Increase accessibility and availability of comprehensive sexual assault care including PEP and psychosocial support

365 Day National Action Plan to End Gender Violence

This campaign, begun in 2006, is a National Action Plan that applies a multi-sector framework and approach for ending GBV. The plan recognizes that GBV is a cross-sectoral problem and that it requires action from all stakeholders across multiple arenas on a continuous, year-round basis. The intention is that all the South African government departments and civil society organizations will 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 addressing GBV.

The campaign enforces one consistent message, namely, to encourage individuals and communities to speak out to stop violence by reporting any form of violence perpetrated by calling a toll free number or a police call Center.

Civil society also implements other awareness raising campaigns, notably, the "16 Days of Activism against Gender Violence" Campaign, which begins on November 25, and ends on December 10, on Human Rights Day. The 16 days campaign is commemorated all over the country to create awareness against GBV and also emphasizes it should be highlighted throughout the year—not only limited to 16 days.

SAG Government Departments and related GBV work

In addition to legislation, there exist several programs and mandates across SAG Departments, which aim to prevent GBV, provide care for survivors, and prosecute offenders. However, the implementation of

legislation, full funding and staffing programs, and coordination across a variety of priorities and approaches have constituted significant challenges.

Department of Women, Children and Persons with Disabilities

The Department for Women, Children and Persons with Disabilities (DWCPD) was established in October of 2009 to emphasize the need for equity and access to development opportunities for vulnerable groups within South African society. DWCPD was created to replace the Office on the Status of Women and its former national multi-agency structure, which lacked sufficient financial and human resources and the necessary authority to co-ordinate and oversee its mandate. The DWCPD draws on presidential authority to facilitate its work and the integration of gender, disability and children's rights into the work of all publicly funded agencies.

The purpose of the DWCPD is to drive the government's equity, equality and empowerment agenda with regard to marginalized groups and historically disadvantaged communities in each of the three sectors. Its mission is to create an enabling environment that translates constitutional obligations, policies and legislative frameworks into the realization of gender, disability and children's rights.

The DWCPD is currently staffed by approximately 60 people, with 4 staff members focused on gender, with plans to expand to 191 staff in three years and to establish several units, including one focused specifically on violence against women.

The DWCPD does not see itself as an implementer, but rather a coordinator of all SAG GBV activities including monitoring, coordination and advocacy. Its primary activity over the next few years will be to draft a new Gender Equity Bill, which will consolidate existing legislation that touches on gender issues, and address any gaps. It seeks to centralize GBV efforts in government, including the coordination of the Inter Departmental Management Team on gender-based violence (consisting of 7 SAG departments), and implementation of the two campaigns, 16 Days and 365 Days of Activism Against Sexual Violence. It also intends to revitalize the National Gender Machinery and hold coordination meetings with SAG and civil society representatives every two months on gender-related topics.

Sexual Offenses and Community Affairs Unit and National Prosecuting Authority

The Sexual Offenses and Community Affairs (SOCA) Unit falls under the jurisdiction of the National Prosecuting Authority (NPA) in the Department of Justice and Constitutional Development (DOJCD). Its areas of focus are: 1) Domestic Violence, 2) Sexual Abuse, 3) Trafficking, 4) Child Maintenance (Child Support), and 5) Child Justice.

The Inter Departmental Management Team (IDMT) was formed in 2000 with a parliamentary mandate to develop and implement an anti-rape strategy alongside a communication strategy on sexual offences in the country. It is an intersectoral initiative, led by the DOJCD, through the NPA-SOCA Unit, and including the DCS, DOE, Department of Social Development, South African Police Service, Department of Health, National Treasury and the parastatal South African Broadcasting Corporation (SABC). The Inter Departmental Management Team has received assistance from various international, national, provincial, and local partners such as the USG, UNICEF, the Danish Government (DANIDA) and the European Unions (EU). A principal component of the work coordinated under the IDMT is oversight of the TCC, which are described in detail below.

Department of Social Development

The Department of Social Development (DSD) works on gender and GBV on two levels. It has a Gender Directorate, which deals with gender mainstreaming within DSD, and it implements and coordinates the Victim Empowerment Program (VEP), established in 1998, at the national and provincial level.

DSD is charged with delivery of social services for GBV; 85% of these services are delivered through funding to CSOs providing trauma care, psychosocial care and support and shelters (97 currently, mostly urban). It also compiles a National Resource Directory for referral.

DSD has authored several strategies— on domestic violence, men and boys, and shelters— that are currently being reviewed and revised. It also supports research on domestic violence, organizes campaigns such as National Trafficking Week, and participates in the National Shelter Movement that coordinates the shelters in all provinces. DSD is implementing the National Victim's Satisfaction Survey, which will produce a final report by June, including information from TCC clients.

Department of Health

The Department of Health (DOH) has a Gender Unit, whose main responsibility is to address gender within four outcome areas, namely:

- Increase life expectancy of women through empowering women to improve their lives
- Reduce maternal mortality rates and child mortality rates to meet the Millennium Development Goals
- Reduce HIV, Malaria, TB and other communicable diseases to increase the life expectancy of people in the community
- Strengthen health systems for people to access quality health services.

The DOH provides rape care through trauma rooms in hospitals, and, on a case-by-case basis, to the DSD's Crisis Centers. It was also involved in early efforts to implement the Men as Partners program, a training curricula that targets men's gender norms and behaviors. In 2002 the DOH developed Gender Policy Guidelines for the Health Sector, focused on mainstreaming gender equality into all of the department's programs, directorates and institutions.[48]

The lack of a dedicated budget and sufficient authority to coordinate the GBV activities limits the Gender Unit's ability to implement its work. Nevertheless, the DOH is conducting a gender audit nationally and at provincial levels this year. It will use the gender audit results to identify gaps and opportunities for integration, with an initial focus on maternal health and HIV outcome areas and continue to oversee the gender activities across other Directorates within DOH.

South African Police Service

According to the South African Police Service (SAPS), the police are first responders dealing with the social context of GBV and crime scene management. As part of DSD's Victim Empowerment Program, all police officers are given a manual on communicating with victims and providing referrals. In 2010 a new unit, the Family Violence and Child Protection (FVCP), was formed within the detective services. 176 Child Protection Units that were previously disbanded in 2007 have been re-established. Each cluster of 6 to 7 police stations has one FVCP unit that investigates rape, incest, indecent assault, attempted murder, kidnapping and abduction. They are in the process of creating a "pocketbook guide" on FVCP services and hope to train other SAG Departments and CSOs to use it.

SAPS provides a five-day basic training for police already in the field, but it is not integrated into the police college curriculum. There is also a National Instruction on Domestic Violence guiding all police how to work

with DV victims, and a commission to report non-compliance by police. Out of 1,121 police stations nationally, there are victim-friendly rooms in 900 of them (or 80%). There are also victim-friendly rooms in some hospitals that have 24-hour police officers stationed there, as well as some in CSO facilities. In areas where victim-friendly rooms do not exist, according to SAPS, detectives sometimes make their offices available for interviewing survivors.[49]

IV. Overview of current programming

GBV Services

Thuthuzela Care Centers

One of the key responses of the SAG to the need to provide care to victims of sexual assault has been to establish Thuthuzela Care Centers (TCC). These centers are overseen by SOCA and the IDMT and have been supported through funding from the SAG, the USG under the Women's Justice and Empowerment Initiative (WJEI) and previously the Local Government Support Program (LGSP), as well as funding from DANIDA to UNICEF. By the end of 2012, 52 TCCs are expected to be running across 9 provinces and the NPA has the goal of establishing a total of 80.

The goals of the TCCs are to reduce secondary victimization, reduce the cycle time to finalization of legal cases and improve the perpetrator conviction rate. The TCCs are located in hospitals and have dedicated SAPS personnel so a victim can make a statement if they choose and receive medical services including PEP and STI testing. In some cases, victims also receive psychosocial services (funded through DSD and delivered by CSOs) in the same facility or are referred to services off-site. TCCs are staffed during business hours Monday to Friday 8:00- 16:00 by an On-Site Coordinator, a Case Manager and a Victim Assistance Officer, who provide services, explain legal and medical procedures and follow up on the survivor's legal case. SOCA provincial liaisons are responsible for working with the TCCs in their province and TCCs have monthly stakeholder meetings to discuss and resolve issues. Some limited outreach and awareness raising activities are also conducted within the community surrounding each TCC. Most TCCs do not handle domestic violence or Trafficking in Persons (TIP) cases, but some TCCs in remote locations with smaller caseloads have started to see these victims as well.

Overall, the TCC model in South Africa is a success story in a government taking ownership of delivering services to treat victims of sexual violence. The South African government has created the program and is committed to sustaining it; in fact SOCA has already absorbed a number of TCC staff that were originally funded through USAID. The conviction rates have increased from an average of 7% to 60% among TCC clients who choose to open a case.

One Stop Centers

In 2003 the DSD began establishing One Stop Crisis Centers to treat victims of crime and violence. These centers provide a variety of services including short and long term psychosocial support as well as an affiliated shelter. They have already established three through UN funding and plan to establish three more through the EU with the goal of establishing nine One Stop Centers, one in each province. The DSD considers the One Stop Center to be the best practice model in Gauteng Province. These One-Stop Centers differ from TCCs because they focus on GBV more broadly and provide long-term psychosocial care and shelters, while TCCs focus on sexual violence and operate in the hospital and have a whole dedicated team to deal with prosecution of cases from the start to end. One main challenge is poor referral across the GBV

service points. DSD would like to establish a marketing strategy to sensitize the public about GBV and to raise awareness of One-Stop Centers.

Medical Crisis Centers

Many hospitals have crisis centers, which provide services for victims of gender-based violence. For example, there are 43 crisis centers throughout KZN, though the extent and coverage differs from province to province. The staffing of these centers varies, including whether or not it has a dedicated doctor and what level of priority the GBV cases receive. Victims come to these centers to receive medical treatment, but are often required to go elsewhere to give a statement to the police and then have to visit another part of the hospital to receive psychosocial treatment and other services. In this model, there is no central person responsible for following up on whether or not the victim received the services needed or to track progress on the legal case.

In addition to separate areas within hospitals, SAG requires all health centers and hospitals to provide free access to post exposure prophylaxis (PEP) for those who have been involuntarily exposed to HIV. The USG is funding the Population Council to work with DOH, SAPS and DCS in four provinces to strengthen the systems for implementation of PEP delivery, increase the capacity of service providers, and increase access to and use of PEP for those most at risk.

Victim Empowerment Centers in Police Stations

In addition to crisis centers for health services, as part of the national Victim Empowerment Program coordinated by DSD, police stations across South Africa are required to have victim empowerment rooms to provide assistance and referrals to victims of sexual violence. The staff at the centers are volunteers and there is no funding for the upkeep of victim empowerment rooms, so while the team met extremely knowledgeable and dedicated volunteers at one police station in the Durban area who had managed to get the police to give them a facility that volunteers then converted into a shelter, it appears this is an exception.

CSO services

There is an array of CSOs in South Africa working on GBV, some providing specific types of services in particular areas, and others with a more comprehensive program. Again, due to limited time, the team did not do an exhaustive review of the range of organizations offering services. One of the most comprehensive programs is the Greater Nelspruit Rape Intervention Program (GRIP) that serves 26 locations in Mpumalanga province. This program provided support to 2194 survivors of rape and domestic violence in 2010, including 9% men. GRIP uses a comprehensive, victim-centered approach and relies on volunteer counselors. Potential counselors receive two weeks of classroom training and one week of practice and GRIP subsequently selects which ones to accept as volunteers.

GRIP has established partnerships with SAPS, government hospitals and regional courts, and has regular stakeholder meetings. They have care rooms in police stations and hospitals, staffed by volunteer counselors 24x7 who also make follow-up home visits and work with survivors for up to a year, helping to arrange psychological, legal and other services. GRIP uses cash incentives to increase its rates of follow ups, providing reimbursement for travel when survivors return for follow up visits. They report that this has dramatically increased uptake of services, adherence to PEP regimens to prevent HIV, and successfully prosecuted cases.

In addition, GRIP has special care rooms in courts and programming for survivors affected by HIV and for parents of minors affected by sexual violence. They work to educate chief's wives, in conjunction with

COGTA (Cooperative Governance and Traditional Affairs). GRIP has recently opened a shelter for women and children in Nelspruit, which is funded by DSD and the private sector consulting company KPMG. Furthermore, they conduct community awareness activities with schools, churches and other groups, including a project challenging communities to speak out about abuse.

The GRIP model is a highly successful victim-centered model, which has shown the ability to provide comprehensive care and long-term support to GBV survivors. Both GRIP and the TCCs have good documentation of their model, including costs associated with establishing and running the program and how to replicate it.

Services for Children

There are a limited number of GBV services focused on children. There are some excellent programs but many service providers that serve both adults and children do not provide specialized programs or staff training on how to handle issues unique to youth. One key provider, Childline, runs a 24-hour hotline which responds to queries from 60,000 to 90,000 adults and children per month on physical, emotional and sexual abuse at home and in school, HIV/AIDS, bullying, relationship problems and other issues. It has a national office and provincial offices, which run independently but provide similar services. Childline provides counseling services in their office and in at least one TCC. They have a court preparation program for child witnesses and a sister organization which runs a Safe House for children (a rarity) in Johannesburg. Childline also provides counseling for child perpetrators and educational programs in schools to prevent GBV and educate children about their rights.

Other Legal and Judicial Services

In terms of the legal response to GBV, dedicated courts were established in 1993, with agreement reached between the NPA and DOJCD to establish special Sexual Offences Courts (SOC). These have been phased out over the past several years due to a judicial streamlining process, because the previous DOJCD minister was concerned about the increased demand SOCs put on limited resources, and that they forced magistrates to specialize. The Ministry supported the integration of these courts into the mainstream court system. There remains an ongoing discussion between the NPA and DOJCD regarding re-establishing these dedicated courts once again, as the ordinary courts are increasingly seen as ill-equipped to deal with GBV cases, adequately and effectively.

The USAID/South Africa Judicial Sector Strengthening Program, to be implemented by the National Center for State Courts (NCSC), will provide support to justice sector institutions to strengthen the prosecution and adjudication of sexual offenses. This will include: technical assistance and training to build the capacity to more effectively manage cases of GBV; analysis of judicial decisions related to GBV; joint training workshops for prosecutors and justice sector actors; a US study visit; and a Judicial Leadership Initiative on changing male norms around GBV.

Research on the magnitude of GBV

USG is considering providing support to the CSO Genderlinks to expand coverage of the provinces included in a national GBV study it recently launched. Currently, the UK Department for International Development (DFID), the Government of Norway and Irish Aid, are funding study in four provinces, with the aim of covering all 9 South African provinces.

Several CSOs have conducted smaller high quality studies of GBV at the provincial level, including the Medical Research Council, Project Concern International, and others, but this will be the first study of its

kind in South Africa and will make a significant contribution toward providing national baseline data, including GBV's links to HIV, to measure progress on GBV and for further investments in GBV programs.

Prevention of GBV

The major focus of SAG's GBV prevention efforts has been on improving the management of the small proportion of sexual and gender-based violence cases that are reported to the police and increasing the rate of prosecution and conviction of perpetrators. It is assumed that increasing the risk of apprehension and the application of stiff sentences will be effective deterrence. While these efforts are an important piece of prevention, they need to be seen *as part* of an overall strategy that includes direct efforts for primary prevention of GBV.

Raising awareness around human rights and GBV related policies, laws, and existing services is essential but not sufficient. There remains an urgent need for more evidence on effective prevention interventions, but there is wide agreement that this must include interventions that focus on the main causal and contributory factors. As previously discussed, there is a confluence of factors that contribute to South Africa's high rates of GBV, including the perpetuation of harmful social norms. Currently, there are several high-profile programs that, while primarily aimed at reducing HIV transmission, address social norms related to GBV such as dominant gender norms, particularly norms for masculinity. Most notable among these are the following:

Sonke Gender Justice

In 2006 this organization launched its national 'One Man Can' campaign' aimed at promoting healthy models of manhood and relationships based on commitment to gender equality. Sonke engages on numerous levels, partnering with government to promote policy implementation, working in communities to build capacity and skills, conducting dialogues, hosting community radio shows, working with traditional leaders, and networking regionally and internationally. In 2009 Sonke launched its first local branch in Khayelitsha township and hopes to expand its local-level actions throughout the country. In that same year it partnered with a coalition of 50 other organizations across the country and the Johns Hopkins Health and Education South Africa initiative (JHHESA) to launch the high-profile, national behavior change and mass media campaign, Brothers for Life.

Brothers for Life

This is a mass media and community mobilization campaign targeting men over the age of 30 and encouraging them to act as positive role models as men, partners, parents and leaders. It has trained a team of ambassadors to promote a new ideal of manhood, focusing on the risk factors that drive HIV, most of which similarly drive GBV. To date this campaign has reached 20,000 people through community dialogues hosted by 100 community-based organizations in 52 communities, and countless others reached through its media work with national television, radio and billboard adverts. Brothers for Life is currently working on a new campaign against child sexual abuse, targeting men who represent a "new man", one who holds other men accountable.

Soul City Institute

This award-winning organization is one of the oldest working to promote healthier lifestyles and changing risk behaviors that drive HIV. GBV has been and continues to be a topic in its on-going media series that includes national television "soapies," and national, regional and community radio broadcasts and dramas. Soul City produces low-literacy materials that are widely distributed through its linkages in several neighboring countries. It also coordinates school-based Soul Buddyz clubs that address issues of HIV, gender, etc., and the alcohol harm reduction campaign Phuza Wise.

Prevention in Action

This initiative of Project Concern International is implemented through the KZN and Western Cape's Networks on Violence Against Women. This program aims at reducing HIV transmission and GBV by mobilizing civil society to create an environment that enables new norms to take root and people to take action against GBV. To date it has trained 120 community engagers with plans to engage 6000 community influencers who will develop ideas for local action to stop GBV, promote awareness and use of the national Stop Gender Violence Helpline number.

IMAGE

This program aims at empowering women economically while simultaneously providing information and education to help them make decisions regarding their vulnerability and risks for HIV and GBV. The project partners with a local financial institution willing to provide small loans to women, allowing them to start their own micro-enterprises. An evaluation and randomized controlled trail published in the Lancet of this program has demonstrated that many women participants were able to avoid abusive relationships and levels of GBV experienced by participants decreased significantly, attesting to the important relationship between women's financial dependence on men and their vulnerability to GBV.

South Africa Clothing and Textile Workers' Union (SACTWU)

The SACTWU holds yearly campaigns to raise awareness on GBV in conjunction with the government's 16 Days of Activism campaign. Through its clinical services, it provides counseling and referrals to women who experience workplace sexual harassment or GBV, as well providing as basic information on HIV prevention, counseling and testing.

South Africa Democratic Teachers' Union (SADTU)

The SADTU is reportedly implementing or planning to implement a Men as Partners program within its structures that aims to change individual attitudes and practices as well as to create a context in which more gender equitable norms can be practiced and in which children are safe from GBV in schools. As discussed elsewhere, there are policies guarding against sexual abuse and violence perpetrated by teachers in the schools, but the union acknowledges that, due to a multiplicity of factors, its ability to enforce those policies is weak.

VI. Gaps and Challenges

While significant progress has been made on the part of SAG, civil society and donors, several challenges to the prevention of GBV and treatment, care and support of GBV survivors remain evident. The overall response has sometimes been marked by poor communication, duplication of efforts, failure to adequately address the root causes of GBV, and insufficiently coordinated services for survivors. The most significant gap pertains to child protection, given the disproportionate burden of GBV experienced by survivors under 18, and increasingly under 12 years old.

Lack of consensus about the magnitude of GBV

Data on the true incidence of GBV are conflicting. To date, while there have been studies on the provincial and multi-province levels, there have been no national studies. Since 1999, South Africa has received heightened international scrutiny of its GBV problem; data related to rape and other sexual offences

remains a very sensitive issue. In addition, data are presented in a format that makes it difficult to draw conclusions, make comparisons or identify trends over time, with data for large gaps in time missing.

Prior to 2007, rape was defined as only male-to-female penetration of the vagina by a penis. Male-to-male rape was classified as "indecent assault" which was considered a lesser crime than rape, and carried no minimum sentence.[50] After the Sexual Offenses Act was passed in 2007, the definition of rape was expanded to include the penetration of a female or male, of the vagina, mouth or anus with a penis, body part or any object. Rape was also was re-categorized under the broad category of "sexual offenses" which includes sex work, pornography and human trafficking. This makes it difficult to assess changes in the number of rapes from year to year, or to assess the incidence of male-to-male rape.

It is impossible to say with certainty whether GBV has increased or decreased, based on SAPS figures. The aggregate figure for all sexual offences in 2009/10 was 68,332, and SAPS estimates that, by using pre-2007 definitions of rape and indecent assault,[51] 55,097 of those sexual offences were rapes.[52] SAPS and other SAG departments claim that there has been a decrease of 11.1% in the number of rapes and indecent assaults reported since 2006/7, hailing this figure publicly as a sign of progress.[53] However, SAPS' Crime Situation in South Africa report for 2006/7 only provides data for rapes and indecent assaults for 6 months of the year, whereas later years provide data for the entire fiscal year (April 1- 31 March), making comparisons between years impossible.

It may be premature to interpret the rise in the number of reported rapes and indecent assaults in SAPS data as a true rise in GBV overall: it could be that a greater number of rapes are being reported due to increased coverage of GBV issues in mass media, increased awareness of rights and that GBV is a crime, and an increased availability of services.

Despite improvements in SAG's GBV response, widespread barriers to reporting still remain, raising the alternate and equally plausible possibility that the increasing figures of reported rapes may only be describing the tip of the GBV iceberg. In fact the Medical Research Council estimated in 2011— based on a GBV prevalence study in Gauteng Province— that only 1 in 25 rapes is even reported to police.[54] In other words, only 3.9% of women interviewed who were raped reported it to the police. Many women are disinclined to report this kind of violence, as they are often socialized to accept abuse and hold little faith in the criminal justice system. Their status within the family may be associated with and maintained by their ability to tolerate hardship and keep matters within the domestic domain.

Women may not report a rape because they could have nowhere else to live but with the perpetrator throughout the duration of the trial, which can take 1-3 years in areas with no TCC or specialized rape services.[55] Survivors report fear of retributive violence by the perpetrator if the case is lost, or if s/he is released from prison early on extremely low bail or for good behavior. Children in particular are often victimized by family members or others in the home, and are afraid to report to adults, sometimes because they fear they may be to blame for their victimization.

Survivors report fearing secondary victimization by poorly trained police officers, health care providers, prosecutors and magistrates who may force them to give their statement multiple times, often in open areas in police stations, and to commute between disparate services during a time of heightened emotional distress. Finally, there is widespread distrust of the criminal justice system: money is sometimes exchanged between perpetrators and officers to "lose" case dockets and crucial evidence.[56] Additionally, fewer than 7-13% of cases resulted in convictions as of 1999 before specialized services were established widely. [57] The significant success of the TCCs in raising the prosecution rate has not been effectively publicized, resulting in continued distrust of the criminal justice system's response to GBV.

Sex disaggregation in GBV data is also of major concern. Although the definition of rape was expanded to include male rape, police officers taking statements do not always note the sex of the perpetrator, making it impossible to calculate the problem of GBV against males vs. females. The police form used to take a survivor's statement when reporting a rape fails to note the sex of either the perpetrator or the survivor, assuming that the perpetrator is always male and the victim is always female.[58] It is up to the police officer taking the statement whether or not to include the gender of the perpetrator and victim.

While a strong patriarchal culture, homophobia and fear of ridicule by police officers often preclude men and boys from reporting rape, data show that men and boys do experience GBV as well as women[59] According to the Medical Research Council, about one in 30 South African men (3.5%) has been raped by a man. [60] [61]

Lack of coordination

Government, civil society and donors all acknowledged that GBV efforts must be coordinated across all sectors, and there is a need to strengthen the capacity of all those working in the field to build sustainability, reduce duplication and enhance collaboration. While SAG has made efforts to coordinate its GBV efforts, there is no dedicated GBV budget and Departments are forced to pool their resources to address growing needs.

Government capacity and coordination

Currently the NPA is taking the lead on GBV across the SAG, as the coordinator of the IDMT and TCCs, reflecting the strong leadership of the Director of SOCA, Advocate Thoko Majokweni. There is also a desire to empower the new DWCPD by giving it a more central role in GBV efforts.

There are some concerns that the DWCPD may not be well-resourced enough to lead GBV efforts effectively. The ministry's first year of work was hindered by structural and political constraints including a lack of capacity, funds and political will. The first Minister was replaced, and there is enthusiasm that the new Minister will be able to deliver on the Department's mandate effectively, both within government and in collaboration with civil society. The DWCPD has work to do to effectively engage CSOs and other departments, who are waiting to see what role the DWCPD will play.

There is concern that the DWCPD's new initiative to draft a Gender Equity Bill will consume the department's limited human and financial resources to such a degree that it will be unable to fulfill its planned coordination role. The Department is also working to get approval on its Strategic Plan from Parliament.[62]

There are individuals within SAG that have expertise and energy, and are working with limited support and resources inside institutions. There is a need to increase the ability of government to design and manage GBV programs and to monitor progress, convene and meaningfully engage with different sectors.

The IDMT is comprised of high-level cabinet members who meet every two months to coordinate all relevant SAG Departments' GBV initiatives. Due to the many responsibilities of its members, however, its priorities and commitments are not always carried out to completion. There is a sense among civil society that members of the IDMT lack sufficient technical expertise in gender issues, and that the forum is closed from civil society participation.

In response to the need for greater collaboration with civil society, the IDMT reported that it convenes a bi-monthly coordination group, the NGM (coordination of the NGM will eventually be carried out by the new DWCPD). Current participation in the group is limited and inconsistent, with civil society partners reporting a lack of focus and direction, and the primary deliverable of the group so far being solely the 16 Days campaign. Due to high turnover in government, campaigns and strategies are sometimes launched without being fully implemented or evaluated. Additionally, staff working on gender in some ministries appears to have limited influence and resources, such as in the DOH.

There is perception among some civil society organizations that there is a lack of transparency around how partners are chosen, who receives funding, and how decisions are made in general. There is not enough clear leadership or sustained political commitment to the issue, and there are few opportunities for public engagement or an ability to hold the government accountable to its commitments.

Inadequate civil society capacity and coordination

Another critical challenge at the community level is that many civil society organizations do not always collaborate with each other or with government, instead competing for limited existing resources and implementing fragmented campaigns. DWCPD and SOCA officials also report a lack of cohesion amongst civil society groups they try to work with. According to SOCA Director Thoko Majokweni, there are over 144,000 registered CSOs in South Africa. Without a national network or umbrella organization, it is difficult for the government to identify which groups they should partner with and fund, or to know who speaks for civil society when it comes to policy and program development.

SAG officials note a particular challenge for organizations run by black South African women who face a multitude of disadvantages compared to those organizations run by white and/or historically advantaged women— some of which have been in existence since the Apartheid era— as it relates to educational opportunity, exposure, effective management skills, marketing of successes, and donor relations. Thus the government consistently prioritizes larger, more established civil society organizations for partnership and funding. As a result, SAG has been accused of racial discrimination and favoritism.

According to the DSD, 85% of their GBV services are provided by CSOs, making it essential that civil society coordinates its response to deal most effectively and efficiently with GBV. Currently CSOs are providing strong models of care in many areas, but lack the capacity and funds to take their programs to scale. DSD is responsible for issuing grants throughout the country to provide services that it does not have the capacity to provide directly, though it has limited resources to administer the grants in a timely and systematic manner. CSOs often cluster in particular areas where donors are eager to provide funding, such as Durban or Cape Town, while leaving out rural areas where it is hard to attract and retain staff. As a result of geographic duplication, some CSOs report fierce competition over funds, clients, territory and constituencies.

Without greater collaboration, CSOs are often unable to complement each other's efforts according to each one's comparative advantage; for example, prevention-focused CSOs could partner with service delivery organizations to raise awareness on the existence of their services. In the current climate, CSOs often try to provide a wide array of services instead of focusing on a smaller number with quality outcomes. As a result, smaller CSOs sometimes have even less capacity to develop good proposals, attract donor funding, measure their work effectively, or showcase results. They are often focusing their passion, efforts, resources and staff on direct service delivery and activities, not on organizational development, websites, marketing, data analysis, etc.

A National Network on Violence Against Women was active until 2004, with 9 provincial corresponding networks. In 2004 it lost funding and collapsed, along with 7 of its 9 provincial networks. The two provincial networks that remain active, in KZN and Western Cape, provide both essential coordination and services, such as training health care providers in post-rape care and newly enacted legislation (e.g. the right of survivors to access PEP) and holding stakeholder provincial consultations on the new Gender Bill. They have also begun to engage in prevention efforts with USG funding, for example the Prevention in Action campaign they are implementing with Project Concern International (PCI).

Lack of policy implementation and poor M&E

While SAG has developed excellent legislation such as the Sexual Offences Act, the Domestic Violence Act, etc. that outline a series of rights and are generally supportive of gender equality, it consistently fails to implement such legislation in an effective manner or to monitor progress according to set indicators. Monitoring and evaluation systems for campaigns, interventions and facilities are weak and produce insufficiently robust data that could be used to track progress, evaluate changes in knowledge and behavior or make comparisons. Moreover, there is a lack of awareness among some major sectors of the South African public about the existence of specific gender rights, mechanisms for their protection, and redress of their violation.

For example, not all hospitals have trauma rooms despite a legal mandate to establish them. Survivors are often seen by casualty doctors who may not be sensitized to the special needs of GBV survivors, the need to preserve evidence in order to build a case in court (such as presence of semen, photographs of injuries, fingerprints and clothing), the need to provide PEP to prevent HIV infection within 72 hours, the need for psychosocial support, or at the very least, the clear message that no one deserves to be raped or beaten and it is not the survivor's fault. While SAPS has made significant progress in establishing victim-friendly rooms, 20%of police stations still lack adequate facilities

One issue of high concern is the rejection of testimony in court of forensic nurses. The Criminal Law (Forensic Procedures) Amendment Act 2010[63] mandates that any registered medical practitioner or registered nurse may collect evidence and testify in court. However, the testimony of nurses trained in forensic medicine has been rejected in several courts by untrained magistrates, notably in KZN province. As a result, entire case dockets have been thrown out and cases lost when nurses collected and presented forensic evidence in lieu of a physician. The growing health care worker shortage means that this problem can only increase, especially in rural areas where there are few physicians who can afford to lose a day or more while testifying in court. The KZN NPA Director was unaware that magistrates have been rejecting forensic nurse testimony. The DOH reports that it has no budget for forensic medicine. It is forced to piggyback on its PEP budget to ensure that clinical forensic services are available to GBV survivors on a 24 hour basis.[64]

Underperforming criminal justice system

Survivors of rape and sexual violence often report their cases at police stations where sometimes little or nothing is done to address their complaints or take them seriously. This leads communities to distrust the police and criminal justice system. Such views strongly deter survivors from reporting, with the result that data on the incidence of GBV are incoherent or insufficient. Widespread, publicized corruption and general under-resourcing within the police force, as well as challenges of transformation and restructuring in the detective services, contribute to the problem. While dramatic increases in prosecution have been the hallmark of the TCC approach, access to TCC's specialized courts is limited, and prosecution rates for normal courts are still as low as 7%.[65]

According to the Domestic Violence Act, abusive spouses are mandated to leave the victim's home and turn in any firearms upon prosecution; unfortunately the act is poorly implemented and many survivors, both adults and children, are forced to return home to the perpetrator, who may be a spouse, parent, sibling, or other relative.

Despite efforts to integrate education on appropriate GBV service delivery, there is no mandatory training in South African Police Colleges. Subsequently, survivors may experience secondary victimization when attempting to report a rape; for example survivors have been asked to give statements in public areas of police stations, officers have not believed them and refused to take statements, and officers have blamed the victim for what they were wearing, being intoxicated, or being out late at night. In worst-case scenarios, officers have raped survivors themselves.[66]

Survivors are not instructed on how to properly give a statement, for example sticking to the facts and including relevant details. They are forced to give their statement multiple times, often under extreme duress, and if they do not give the same exact story every time or stick to the facts, the case falls apart in court under apparent contradictions. Clerks are not always properly trained to transcribe survivors' statements and evidence is often lost. According to GBV experts from civil society organizations at the Researcher Roundtable in KZN, survivors who are illiterate have reported being forced to sign statements without being able to read them, and without having statements read to them.

There is a commonly reported misconception— contrary to South African legislation— among police that a victim must file a report in the jurisdiction in which she lives, or, conversely, the jurisdiction in which the assault took place. Survivors are shuttled around back and forth from station to station when in reality, according to the law, a person can report to any station. Police and health service providers have also been under the misconception that a survivor must file a police report before accessing PEP. In some cases, survivors have been denied access to PEP within its 72-hour period of efficacy because they refused to file a case against their perpetrator(s).[67]

In addition to rejecting testimony from nurses trained in forensic care, magistrates and prosecutors who are untrained in working with GBV survivors also perpetuate secondary victimization by traumatizing unprepared survivors in court. A long backlog of cases means that the case duration can take up to 3 years to reach a conclusion. Court cases are sometimes held where the incident occurred and the survivor cannot afford regular transport there. While cases are being processed, survivors report they have had nowhere else to live but in the same community with the perpetrator.

Insufficient training of service providers and officials

While some CSOs have attempted to integrate comprehensive GBV training into the regular instruction of nurses, doctors, police, prosecutors, magistrates, teachers, *et al*; by and large, efforts have not been successful.

Service providers and authority figures need training in order to be able to identify survivors, support disclosure, provide appropriate referrals, and deliver quality care. Nurses and police who are trained to deal with sexual assault as part of DSD's Victim's Empowerment Program are often assigned to other pressing duties, watering down the facility's ability to respond to GBV adequately.

There is a national 10-day training on GBV for health service providers which is a crucial first step, but it is so long in duration that few medical facilities are able to release precious staff for so long. Thus, there are an inadequate number of trained health care providers, especially those trained in forensic medicine.

Magistrates and Prosecutors are not attracted to work in dedicated or designated sexual offense courts because this is viewed as a stagnant career path with few incentives or opportunities for professional growth.

Adding to the challenge that some magistrates do not accept testimony from nurses trained in forensic care, the South African Nursing Council does a further disservice to GBV survivors by failing to accredit forensic training. Unlike nurses who are specially trained in other areas, forensic nurses do not earn any additional salary or official certification. As a result, fewer nurses are enrolling in such training, and thus fewer competent staff are available to collect evidence and build a solid case for rape survivors. This is of particular concern given South Africa's emphasis on delivering medical care through primary health care providers, with a heavy reliance on the nursing system. Requiring a physician to be present for every rape survivor seriously impinges upon a facility's task-shifting capabilities.

Inadequate and inconsistent services where there are no TCCs

While there are currently 52 TCCs nationwide and plans to build a total of 80, as well as some nascent efforts for other coordinated models of care, many geographic areas lack access to specialized services. Hospitals are supposed to have crisis centers for survivors of sexual assault, but staffing and resources in these facilities vary greatly. As a result, survivors are often seen by untrained casualty doctors who may not have private facilities to give medical exams, areas where the survivor can bathe and change into clean clothes afterwards, or access to psychosocial counseling. Crucial evidence can sometimes be lost, and it may take survivors several days to access all the services s/he needs (a medical exam, police report, counseling, PEP provision— if it is not too late, STI treatment, etc.)

TCCs' remaining challenges

Although significant achievements in post-rape care have been made by the TCCs and they have been hailed internationally as a best practice model, there remain several areas for improvement. In SAG's efforts to better partner with CSOs, the establishment of TCCs has been an area of great potential for harmonization of efforts, but also a challenging process. RTI has prioritized provincial and local stakeholder meetings that identify CSOs in areas where TCCs will be established, and in areas where DSD is unable to provide enough staff for psychosocial counseling and social work, some CSOs have been contracted and paid by RTI to continue to provide specific services via the TCCs (or as a complement to the TCCs)--mainly after-hours care, psychosocial support, HIV support groups and follow up visits. However, several CSOs report having been uprooted and transferred to other areas, sometimes when they have been operating in (and living in) those communities for years, developing good relations with community gatekeepers and members.

In revisions of the TCC blueprint it will be important to further develop the role of—and guidelines for—CSOs that provide services to TCC clients. Currently the provision of after-hours care lacks the same level of monitoring as care provided during the regular office hours of 8:00- 16:00. Because most rapes occur at night, on weekends and holidays, consistency in after-hours care is crucial. TCCs have made provisions for case managers to review patients who are night intakes; however, by nature, each CSO will be different and it is difficult to ensure quality services across all TCCs, especially in rural areas where CSOs' capacity may be less comparable to well-established urban centers. Equally important is the need to fund CSOs adequately to provide such services. RTI reports that some CSOs have been paid under contracts with TCCs, but obtaining and disbursing the adequate compensation required in order to produce quality, consistent results is still a pending challenge.

TCCs have difficulty attracting and retaining staff in remote areas, especially given the demands of the job of providing post rape-care and trauma services. This problem is not limited to the TCCs alone but extends to other mandates and care models of SAG and CSOs. Without dynamic partnership with more community-based organizations SAG seems to be having a difficult time strengthening its 24-hour services, its ability to follow up with survivors, and its ability to raise awareness in communities about GBV and the availability of services.

Providers report that survivors are sometimes transported many kilometers away from their homes to be seen at a TCC, making it difficult to return for follow up care such as a complete PEP dose and counseling. Sometimes even when survivors are referred back to facilities closer to their home they are lost to follow up simply due to the secondary victimization created when a survivor must tell her or his story repeatedly and recollect the assault in detail.

Currently, the TCCs take a prosecution-focused approach. While the model is supposed to reduce secondary victimization, mainly by providing all the services in one place, adopting a stronger victim-focused approach would allow the blueprint to evolve in such a way to better meet the needs of the survivor. The lack of sufficient involvement in the TCC model by the DOH, who run their own crisis centers out of hospitals, means that there is too little focus on treating and documenting adverse health outcomes, STI incidence, PEP adherence and mental health.

Although there have been some limited community awareness-raising activities through the TCCs, there is a great need to increase awareness of GBV related services, and increase community buy-in. The TCCs do not advertise effectively, they are difficult to locate, and they do not have a website- only an outdated flyer listing 17 of the 52 facilities. TCCs appear to receive clients mainly through referrals from other facilities, but some facilities with a TCC in their surroundings were unaware that it existed (for example, Victim's Empowerment Center staff at a police station near Durban, in the same district as a TCC in KZN). Some hospital staff were even unable to direct the team to the TCC within their own compound.

Inconsistent access to PEP

While all health facilities are mandated to stock PEP formularies and supplies, survivors are not always offered treatment due to poor training of service providers and the lack of widely available policies, guidelines and flow charts. Child survivors are particularly difficult, as physicians sometimes cannot calculate the correct formulary of ARVs to provide. Police who take rape reports do not always bring the survivors to the facility within 72 hours, in time to give PEP. In the past there were cases in which rape survivors chose not to report their rapes to the police and were denied PEP as a result. The DOH has taken steps to correct this, including communicating policies on PEP access to all health care providers.

Those facilities that do provide PEP need better data management systems to monitor the delivery of PEP, adherence and outcomes. Children, men who have sex with men, migrants, refugees, immigrants, and incarcerated populations face particular difficulties in accessing PEP since untrained providers do not perceive them as "at risk" or capable of adhering to a full treatment of PEP due to often unstable living environments.

Inadequate prevention of violence and awareness of rights

In general, there is a major gap in South Africa regarding knowledge of what constitutes GBV, what is illegal, and what are people's rights. Given South Africa's patriarchal culture and traditional practices, there is a fundamental need to address knowledge, attitudes and behaviors at the community level. While most people are aware that rape is wrong, nuances such as marital rape or statutory rape are often lost.

Female survivors in KZN, for example, report being groomed from a young age to believe that marriage is a test of endurance and sacrifice. Some young women report being told by their mothers when they get married that "your grave is with your in-laws now." Once their *lobola* (bride price) has been paid, they are often perceived to be the property of their husbands, and are expected to endure beatings, rape, infidelity, polygamy and/or possible HIV infection with grace, never speaking of it outside the family. Women raised in this way are unlikely to report rape or to access services. Thus, engagement work is crucial for entire families, including children and parents, as well as traditional authorities who are widely regarded and respected as custodians of culture and tradition.

Insufficient culturally-grounded community prevention programs

Some current GBV prevention programs are of a vertical, top-down nature without strong mechanisms for community buy-in and participation. Similarly, they lack mechanisms that build community accountability or work with traditional structures that provide redress for social infractions. A common remark is that South African women are "workshopped" and empowered, but then returned to the same disempowering context where they lack agency and decision-making power over their lives.

Because traditional leaders hold enormous sway over the beliefs and practices of many communities, it is important to engage them fully in awareness and prevention interventions. However, without proper training and participation, and perhaps more crucially an approach that demonstrates sensitivity to and respect for traditional institutions, it can be dangerous to rely upon them to adjudicate matters of rape. SAG is currently considering a controversial bill that will return authority to traditional courts. Sometimes traditional leaders have preferred to deal with cases of incest and rape through mediation with the family, often inviting the family of the perpetrator to compensate the victim's family financially without offering further redress. In the worst cases, perpetrators are forced to marry the victims because they will no longer fetch a good enough *lobola*.[68]

Insufficient programs and services for men and boys

Prevention programs— historically focused on women and girls— are beginning to target men and boys, but some still portray men solely as perpetrators or future offenders. While some initiatives do acknowledge the vulnerability of men and boys to sexual and physical violence, there is a need for greater outreach to male survivors and prevention of violence efforts. Prevention programs cannot use simple, binary messages that women are "good" and men are "bad." A more effective approach is to engage men with positive messaging. For example, Brothers for Life recognizes that there are "good" men out there and seeks to engage them to become "community influencers." Such programs need to be further scaled up, particularly in remote, rural areas.

Many campaigns tell men what not to do, some tell them what to do, but very few tell them how to seek rehabilitation. Even CSOs focused specifically on engaging men and boys have difficulty referring men to rehabilitation services beyond self-help and anger management materials or support groups. Psychological services are particularly inaccessible due to widespread stigma against mental health issues. Incarcerated men are even less able to access quality rehabilitative services and may in fact be secondarily victimized while in prison. Men who are gang raped in prison and then released have had their masculinity further invalidated and may return home to further victimize their partners and families.

Lack of programs and services for marginalized groups

South Africa's marginalized populations, such as LGBTI individuals, sex workers and the disabled, often fall through the cracks of the GBV prevention, care and prosecution systems.

The LGBTI community reports facing barriers to accessing mainstream GBV services, such as provider and police discrimination. There are few organizations specifically addressing LGBTI needs and fighting homophobia, and those that do exist operate on limited financial resources. Short-term accommodation for LGBTI individuals in crisis situations, such as the Pride Shelter Trust in Cape Town, is available in many major cities, but there do not seem to be comprehensive services available. According to Luleki Sizwe, an organization fighting "corrective rapes" of lesbians, over the past 10 years, 31 lesbians have been murdered in hate crimes due to their sexuality, and 10 lesbians are raped on Cape Town on a weekly basis.[69] Although the issue of "corrective rapes" has been known for quite some time, an international organization, Change.org, brought attention to the issue by gathering 170,000 signatures from 163 countries, prompting SAG to engage CSOs at a consultative meeting with lesbian organizations in March 2011.[70] As a result of efforts by groups such as the Triangle Project and others mainly in the Western Cape, a bill may soon be passed that criminalizes hate crimes based on sexual orientation.[71]

Sex workers (SWs) in particular have difficulty accessing services because sex work is criminalized in South Africa, and they fear reporting rape in police stations. There is a common belief that "there is no such thing as raping a prostitute" and SWs (and drug users) may be blamed by the police or health care providers who believe that SWs "deserved it." Police are therefore reluctant to open cases for SWs who were raped or sexually assaulted[72] and SWs are sometimes poorly treated by SAPS officers, arrested for prostitution when trying to report rape, extorted for money, or raped again by the police. According to Sisonke,[73] the South African Network of Sex Workers, police harass and victimize SWs on a regular basis. They demand bribes of approximately R300[74] in exchange for not arresting the SWs, and if they do not pay, they are held in jail for several days where they have been deprived of food, water, and medications such as ARVs that need to be taken regularly. SWs who are known to police officers have been arrested for "loitering" even when not working, simply because they were recognized.[75] SWs report being robbed by police officers who know that they cannot open bank accounts to keep their earnings, because a pay slip is needed to open a bank account. In a case brought by the sex worker CSO SWEAT (Sex Worker Education and Advocacy Taskforce) in Cape Town, the High Court recently ruled that the police were guilty of harassing the sex workers.[76] LGBTI groups in Limpopo documented beatings of SWs by police and are calling for an investigation of a police officer caught on camera demanding bribes from SWs. A march they organized to protest police victimization and to advocate for their rights had to be cancelled last minute when the Munisa Local Municipality police station revoked permission for them to march less than 24 hours before the event.[77] Studies show that between 34%- 60% of SWs are HIV positive.[78] [79]

Regarding health care facilities, the hours of operation (usually 8:00-16:00) are almost the opposite of when SWs work and are most likely to be victimized. It is unclear whether or not the after-hours services provided by CSOs at government facilities such as the TCCs are effectively reaching SWs.

Likewise disabled people, especially physically and/or mentally impaired women and girls, are frequent targets for sexual abuse, though the extent of HIV and GBV risk among this group are just starting to be studied in the country. There is a need for services and prevention programs tailored specifically to the needs of marginalized populations.

Limited services for children

Although there is widespread agreement among TCCs, CSOs and other health providers on the general statistic that 60% of survivors accessing health services are under age 18 and a further 40% are under age 12, the majority of services are not child-specific. Some TCCs do have providers trained to work with children (for example giving them anatomically correct dolls to show what happened to them if they are unable to articulate themselves) and have child-friendly trauma rooms and overnight sleeping arrangements. Some designated courts also have closed-circuit television rooms where children can testify

without encountering the perpetrator. However, by and large, child survivors are treated the same as adult survivor and the secondary victimization of children is likely to leave permanent emotional scars.

There is a need to work not only with child survivors but also with child sexual offenders. Some CSOs such as Childline and the Teddy Bear Clinic do have programs for child perpetrators, but they remain too few to adequately address the magnitude of the problem. According to the Child Act, under-age offenders must be placed into rehabilitative programs rather than purely punitive institutions, since they may come from families where they experienced neglect or abuse, or were OVCs. Sexual violence, physical abuse and emotional neglect of children are documented to result frequently in perpetration of violence against others later in life. Girls are usually taught to internalize pain, fear, anger and sadness, whereas boys are taught to externalize it, often through perpetrating violence themselves. Additionally, children who grow up in highly unequal, violent families often have difficulty delineating between consensual sex and forced or coerced sex. [80]

Lack of alternatives for care and safety for child and adult survivors

Both children and women with children have enormous difficulty in leaving abusive homes and situations. Due to South Africa's high rates of unemployment, women commonly rely upon their male partners for household income. In abusive homes, women are less likely to participate in household decision-making over purchases, health care, schooling, etc. Women whose partners perpetrate violence often find themselves unable to leave due to loss of income, stigma against women who are blamed for failed marriages, pressure from family who are unable or unwilling to return bridewealth, and most importantly because they have nowhere to go. There are few formal childcare services available, and women who depend on government support must live on only R200/month.[81]

There are very few shelters overall, and fewer still that accept women who have children, especially boys over 10 years old. The National Shelter Movement and DSD are both prioritizing building more shelters, but the need is far greater than their ability to keep up with demand. According to the KZN Network on Violence Against Women, women in shelters are given an allowance of R40-R70/day[82] for both them and their children, while perpetrators in prison cost R150-R200/day.[83] Since court cases usually take between 6 months- 3 years for prosecution, women without access to shelters frequently drop charges because they must face their perpetrator (and sometimes his family) in their communities.

The DSD does not support a model of residential OVC shelters or orphanages, preferring instead to recruit families to temporarily foster children. However, given the rising cost of living, food prices, increasing instabilities in families with falling marriage rates, rising teenage pregnancies, and unemployment, fewer families find themselves able or willing to take on additional children to care for.

Lack of adequate prevention, care and treatment in schools

Children of school age are well suited to learn and adopt new behaviors and attitudes. Thus the Life Orientation program offers a crucial opportunity to influence impressionable minds for the better to ensure healthy relationships and to prevent violence. However the current Life Orientation curriculum consists of only one session in some cases, and students are not tested on what they have learned as with other subjects. Therefore both the teacher and student give LO programs scant attention and the program is poorly monitored. The curriculum itself does not seem to deal effectively with the awareness of or prevention of GBV.

Teachers' pre-service training does not focus on the prevention of sexual abuse and harassment by teachers, nor does it instruct teachers how to deal with disclosure of abuse, how to identify signs of abuse,

or how to deal effectively with incidents of abuse, providing appropriate referrals and reporting incidents to SAPS. A recent incident in which a six year-old boy who was raped and the teacher brought him round to each classroom in the school to point out his perpetrator only reflects the enormous potential for secondary victimization by teachers, who are often the only potential role models and authority figures in some children's lives.

Students have been coerced into having sex with lecturers and were threatened to keep quiet about it, especially those in their final year, whose marks and oftentimes careers depend on passing the course. The teachers' union SADTU offers a voluntary Men as Partners GBV training program, but it is not mandatory for its 253,000 members (2/3 of all South African teachers). SADTU has a difficult relationship with the DOE and reports that due to constant turnover at the DOE it is challenging to follow up when they try to build relationships with SAG officials. Overall, there is a culture of impunity around teachers who abuse- they are not always expelled from the union or dismissed as teachers but remain in their positions and are able to perpetrate again. Sexual harassment by peers is also reportedly very common. Most schools lack policies or codes of conduct on how to deal with sexual harassment. Current protocols deal more with covering up incidents rather than providing support and justice.

VII. Conclusion and Recommendations for USG/South Africa

U.S. Secretary of State Clinton has called for concerted and sustained attention to the issues that undermine the potential and well-being of women and children around the world; principal among them, gender-based violence. PEPFAR 2 and the Global Health Initiative affirm USG's commitment to address GBV, along with unique vulnerabilities of women and girls, men and boys, as an important input to attaining health outcomes and for the achievement of gender equality as an end in itself.

The ultimate goal of GBV work in South Africa is to help women and girls, men and boys, and, by extension, communities as a whole, realize their health and human rights, and to deepen democracy in South Africa. USG has an important role to play in supporting the South African government and civil society to achieve these critical goals.

The complex nature of GBV requires a multi-faceted response. As such, the focus of USG-supported GBV programming should encompass *prevention*; *medical, social and legal services*; and national and provincial *coordination and policy*. The recommendations delineated below are organized according to each level. They reflect areas that fall within the purview and manageable interest of USG/South Africa, address needs identified through the assessment, and contribute to focus areas and priorities of SAG and civil society.

Based on the team's assessment of the current situation, key gaps, and the relative level of effort to date in each area, the team recommends that the USG portfolio devote roughly 60% of the total GBV budget for prevention programming; 30% for services, both medical services as well as those related to psychosocial, legal and judicial support; and 10% to national and provincial coordination and policy implementation. The team is using the figures provided by the country team, roughly US $20 million, based on PEPFAR GBV secondary budget attribution and funds planned for the TCCs, as the baseline for this breakdown. Given limited resources overall, the team prioritized by first, second, and third tier activities within each programming area. The prioritization roughly reflects degree to which the recommendations are 'low-hanging fruit' or most actionable in the short term, serve as a precursor for other actions, and/or require medium and longer term efforts or additional inputs not readily available or immediate purview of USG.

The funding and attention to prevention activities should not come at the expense of improving the quality of services, as outlined below, but will allow for strategic and intensive focus on prevention. The intent is to assist in shifting SAG and CSO prevention efforts beyond an emphasis on GBV awareness-raising activities and prosecution towards more comprehensive and transformative work rooted at the community level. As recommendations are being implemented, USG/South Africa should revisit the distribution of resources to determine progress in each area of programming. Given the magnitude of the issue and the programmatic needs at various levels, as outlined below, the GBV assessment team encourages USG/South Africa to consider increases in funding for GBV over time.

Prevention

In addition to those listed in this report, there are many other prevention programs that identify changing gender norms as part of their mandate, but for most if not all, GBV prevention is tangential to their broader gender transformation goals. While programs aimed at changing gender norms are important, they do not necessarily involve GBV related topics, and it cannot be assumed that the changes that ensue will lead to reductions in GBV. There remains a need for interventions that directly address GBV prevention in a focused and systematic way. Effective and sustainable prevention requires national-level efforts linked to low-cost, community actions that foster changes in ideologies and social practices supportive of GBV and more specifically society's tolerance to GBV and women and girls' psychological resilience to rape.

Primary prevention should involve programs for both short-term results (i.e. better regulation of sales and use of alcohol) and longer-term goals (i.e. changing prevailing gender norms and creation of zero tolerance for gender-based coercion and violence in communities). GBV prevention will also require— among other things—commitment and strong leadership as well as on-going interventions, particularly in the form of public awareness campaigns, community engagement and psychosocial counseling services.

Filling the gap in GBV prevention services should go beyond common top-down approaches and the provision of after-the-fact services and support. National campaigns by government are often perceived to be poorly coordinated, of limited duration, and have little reach or depth into communities. Sometimes campaigns by civil society organizations overlook the role and capacities of local networks and structures, such as traditional leaders who are well placed to influence cultural practices, customary laws and habits, and mobilize communities around issues that affect them.

Effective programs to prevent GBV are likely to be those that build upon existing structures within communities and resonate with peoples' beliefs, values and understandings of GBV. Of importance would be the leveraging of faith-based institutions with their multiple structures for reaching youth and various formations of men and women, traditional leaders such as chiefs, their wives and councils, ritual authorities, traditional healers, parent-teacher associations, taxi and tavern associations, and local savings clubs known as "stokvels" as well as sports clubs. The primary goal of high quality community-level work to prevent GBV should be the strengthening of currently weak community sanctions against perpetrators and reducing social tolerance for GBV. Reaching this goal requires programs that offer the opportunity for people to learn about the nature, the extent and the social impact of GBV (in addition to learning about human rights, relevant laws and available services), and then to strategize ways that they can take action wherever it occurs, whether in the home, school, drinking establishment, on the streets or elsewhere.

First Tier

- USG partners need to form stronger partnerships among themselves and others doing related work at national, provincial and local levels to develop coordinated and impactful GBV prevention. This includes directing partners to identify and better engage with existing structures within local communities to ensure those most affected are adequately reached, and to avoid duplication of efforts; and linking GBV

prevention programs to other prevention, care and support activities at district, provincial and national level.

- USG should ensure that its current GBV and HIV prevention programming: saturates exposure to GBV prevention and awareness of existing services within communities, while tailoring messages to what is most appropriate locally; avoids development of new brands, campaigns and materials; and uses community-centered and participatory approaches. These approaches include interactive communication tools and strategies such as digital stories, community dialogues, role-play and edu-tainment, local radio phone-in programs, talks by GBV champions, etc. The SHIPP program provides an opportunity to test this out and it is recommended that GBV prevention be inserted into SHIPP programming as a key topic.

- Continue successful models working with men and boys, and support interventions that provide psycho-social counseling to boys and men that help them manage anger, pain and frustration in ways other than through perpetrating GBV.

- Support income generation interventions that build the capacity of women and girls and educate them about GBV and HIV/AIDS, such as the IMAGE project, through a public-private partnership. Link these to programs that work in coordination with— and for the empowerment of— men and boys, and assist them to adapt positively to the changing status of women.

- Increase focus on children and youth. Much remains to be done through the schools for inculcating improved attitudes in the next generation for healthier gender relations. The Life Orientation Curriculum is currently under review by the Department of Basic Education, providing a key opportunity for USG to ensure that the program is comprehensive, harmonized, and evidence-based, targets harmful gender norms, and builds awareness of GBV services. It should be incorporated into school exams to ensure that teachers give the program adequate time. Examples from USAID's Safe Schools Projects and Go Girls! Initiative, CDC's Family Matters Program, and other similar programs that have been implemented in other contexts should be explored and tailored to the South African context in order to create a shift in attitudes and knowledge of both students and teachers in respect to GBV.

- Assist/encourage government and civil society to study and acknowledge the linkages between alcohol and drug abuse (by men, women, and youth ages 10-24) and GBV, and to take visible and firm steps to enforce current liquor laws, and better regulate sales, distribution, and advertising to promote reduced alcohol consumption.

Second tier

- To date the toll-free Stop Gender Violence Hotline only applies to landlines, while many South Africans use mobile phones exclusively. USG should work with cell phone networks (MTN, Cell-C, VODAFONE) to allow for calls to this hotline to be made from mobile phones free of charge.

- To support SAG in its desire to improve data on GBV, USG should continue to support research efforts by providing technical assistance, communicating with partners and donors to ensure efforts are coordinated, and creating linkages to other programmatic areas (such as the sexual prevention of HIV) and disseminating findings.

Third tier

- Provide technical assistance and support to mentor, build capacity and hone the skills of African women and men to take leadership positions in the GBV sector and to more effectively address the problem, both within the CSO and government sectors.

- In addition to what organizations are already doing through the national media, USG should support partners, such as Soul City, to strengthen partnership with SABC to encourage them to provide free or subsidized infomercials with consistent and correct GBV messages. The SABC is part of the IDMT and as such is responsible for GBV program content and could provide a valuable contribution.

Services

As discussed above, there are many providers of services for victims of gender-based violence in South Africa. Although there have been efforts amongst both SAG and CSOs to coordinate these models and services, there still appear to be many separate models as well as gaps and overlap in services being provided. The team recommends that USAID/South Africa allocate approximately 30% of its GBV funds to service provision, through the following activities:

First Tier

- A comprehensive review of the different service delivery models in South Africa, in collaboration with SAG, especially those supported by the government. This should result in a map at provincial and district levels of the variety of models, including TCCs, crisis centers that meet minimum standards of services, functional police VEP units, and one stop centers, and should also include information about shelters and services provided by CSOs. This should not be limited to the TCCs nor is it intended to be an additional evaluation of the TCCs or the other models; rather, it is meant to strengthen overall response by clearly laying out the range of models that exist, identifying a plan to ensure adequate coverage across the country through the most appropriate and realistic combination of models, and facilitating the application of quality standards across all models. Some of this information has already been collected and exists in documents such as:

    - **2011 TCC Cost Effectiveness Study**. UNICEF recently conducted an assessment of the TCCs' cost effectiveness on the 12 centers it supports with DANIDA funding. It is currently with SOCA for final approval but will be released shortly.

    - **2009 Lessons in the Implementation of Health and Victim Empowerment Policy Applicable to Rape Survivors.** This study was commissioned by AED funded through USAID/ PEPFAR.[84]

    - **2007 TCC Gap Analysis Report:** Final Report on the Compliance Assessment of the TCCs with National Department of Health Guidelines for Managing HIV in the Context of Sexual Assault. This report was funded by USAID and was part of an initial assessment of possible interventions to assist the NPA/SOCA in developing the TCC model.[85]

    - **2003 SAGBVHI report: The state of Sexual Assault Services in South Africa.** The aim of this study was to investigate sexual assault services provided by the DOH in South Africa with an in-depth look at North West Province.[86]

    - **DSD referral directory of CSO services**

    - **National Audit of Multi-Disciplinary Services in South Africa dealing with Sexual Offences.** The audit was commissioned by the (IDMT), in response to the need to establish additional TCCs nationally and was conducted between February and April 2009, including an analysis of 76 health care facilities across the 9 provinces.

- **An evaluation of Medico-Legal services in Gauteng: Implications for the Development of Best Practices in the After-Care of Rape Survivors**

Some additional information may likely need to be collected, and all of the information will need to be comprehensively compiled into one report. This combined information should be used to determine where there are gaps in service provision and to develop a strategy on how to ensure that each district has sufficient coverage for the provision of services, either through a TCC, a combination of functional crisis centers and VEP units or other methods that are cost effective and appropriate for that location. The type of service model to be implemented in any location or setting should respond to available resources (organizations, etc) and needs on the ground. The model for the provision of medical care should ensure that all facilities and their staff are equipped to administer PEP and emergency contraception.

This report should lay out the minimum standards for these various service provision mechanisms and may propose minor adjustments to current models to address the realities of the needs and capacity of the system. It should also include information on how to establish and retain enhanced coordination between these various service providers within the provinces, including CSOs, and how to create ongoing links and synergies with current prevention programs. To the extent possible, services for men and LGBTI, albeit limited, should also be included in the mapping.

- Direct efforts to strengthening the TCCs, building on the great deal of support to the TCCs, which the USG has and will continue to provide through a public-private partnership with MAC-AIDS and other USG funding. USG should work to address the gaps noted in the recent TCC evaluation, in the 2009 audit and reports listed above, especially surrounding the comprehensiveness and timeliness of care. This should include a solid plan for:
    - ensuring 24x7 care is available at all TCCs by expanding partnerships with CSOs;
    - informing the surrounding community about the services available at TCCs;
    - determining who should handle domestic violence cases in instances where TCCs don't have the capacity;
    - responding to children victims of violence who present at TCCs;
    - and partnering with DSD to ensure psychosocial, shelter and other important services will be consistently funded and available to the victims who are treated at the TCCs.

This also includes ensuring that TCCs build stronger engagement with communities and CSOs, follow up care and support, and partnerships with an array of referral services. Other topics to consider are how to integrate reliable and safe transport into the TCC Model and how to engage with SANAC to fast-track the accreditation of forensic training for nurses.

- If funding additional TCCs, the decision on placement of the TCC should be based on the mapping and strategy mentioned above, if complete. If the final mapping information is not available, the location of additional TCCs should consider the anticipated level of demand and need and should also be used as a model for implementation of the enhanced TCC blueprint. USG should determine whether fully-equipped TCCs are needed or whether a scaled-down version, perhaps with two instead of three core staff is more appropriate and cost effective. This scaled-down version, or "TCC lite" could be especially suitable in more remote areas, which service fewer people.

- Increase awareness of the existence of the GBV services within communities, including TCCs, including a new website, multi-lingual brochures listing the services provided, hours and locations of TCCs, outreach to community leaders, police stations, hospitals and CSOs to build awareness of TCCs, etc. Awareness raising activities need to target some key actors such as taxi drivers and hairdressers. There

is also a great need to provide women and other community members with information about the South African laws such as the Sexual Offenses Act so they understand their rights. This awareness raising should be coordinated with prevention programs to ensure they complement each other and are not redundant. In order to broaden the reach of the awareness-raising program, information should be shared across other partners and programs, such as through the PCI Prevention in Action networks.

Second tier

- As part of the Judicial Sector Strengthening program, assistance to the Court Administration Unit on the roll-out of the Re Aga Boswa Model and training for court managers should include how to effectively handle GBV cases. The case flow management system, which is intended to provide shared access to information among courts, NPA, corrections, public defense, and police, should include fields that track important information on GBV cases and how they are coordinated and handled.

Coordination and Policy

As noted above, there are several critical gaps in the coordination of GBV response in South Africa. Recommendations address these gaps along three levels of work: 1) within and between government and CSOs, 2) among donors, and 3) across USG programs.

Coordination and Technical Assistance to SAG and CSOs

SAG and civil society representatives who participated in the assessment consistently identified a function for USG in supporting greater coherence and effectiveness of the GBV response in South Africa, namely through coordination and technical assistance in a variety of areas.

First tier

- Participate in the National Gender Machinery and other bodies that exist nationally and provincially.
- Continue participating or play an advisory role to government department initiatives, such as the DOH gender audit and the DSD review of the Domestic Violence and Shelter Strategies. Work with relevant government departments, including priority attention to DWCPD, NPA/SOCA, DSD, DOH, and DOE to identify technical needs and developing a plan to meet those needs, avoid overlap and fragmentation of services
- Continue supporting national and provincial coordinating bodies for GBV CSOs, with the objectives, among others, to: encourage consensus of needs and messages to be communicated to government; make GBV resources and information more readily available to CSOs; avoid duplication of efforts.
- Encourage the reintroduction of sexual offenses courts, regulation for all magistrate courts to accept testimony from forensic nurses, and mandatory pre-service GBV curricula for service providers as well as in-service training for: police, prosecutors, magistrates, health care providers, newly elected politicians and diplomatic corps and teachers; take punitive action against GBV perpetrators who are civil servants and service providers.

Second tier

- Provide technical support to SAG for implementation and monitoring of myriad GBV-related policies that already exist, as identified above. USG should not encourage the development of new policies, duplicative materials, and frameworks. Rather, emphasis should be placed on ensuring that appropriate systems and training is in place to roll-out policies and guidelines at national and sub-national levels, and to apply GBV specific indicators as part of national tracking systems.
- Consider seconding someone to the DWCPD in order to increase capacity of the ministry to serve as convener and to oversee national response, if the USG determines that the ministry would benefit and

be able to fully utilize that assistance. The scope could include the development of a database of existing policies and guidelines on GBV, to assist in the identification and dissemination of policies and protocols that are applicable nationally or are different per province. The person could also serve as a liaison between SAG and USG on the mapping exercise.

Coordination among donors funding GBV initiatives

First tier

The team recommends that USG convene donor GBV roundtables on a regular basis. A donor group was organized for purposes of the GBV assessment so that a range of multilateral and bilateral donors could meet to share information on the technical and geographic scope of respective GBV activities. It became apparent that there are missed opportunities for collaboration at national and provincial levels, and that increased communication could enhance strategic decision making in the focus of assistance and resources. This would include identifying both duplication of services in specific geographic areas where donor funds are concentrated and those areas of poor coverage, such as rural areas and North West province. Participants expressed interest in continuing to meet and are looking to USG for leadership in this regard.

The proposed USAID Gender Advisor (see below) could take the lead in organizing these roundtables. However, given that USG and donor activities of interest go beyond GBV and HIV programming alone, broader donor coordination efforts would ideally fall under the scope of a USG Gender Technical Working Group that cuts across sectors.

Coordination of USG internal efforts

First tier

Just as greater communication and collaboration is needed within SAG and civil society, USG/South Africa should take steps to enhance intra and interagency coordination on GBV. The team recommends that the South Africa Gender Technical Working Group (currently made up of CDC, USAID, Embassy, DoD, and Peace Corps) exchange information on GBV prevention and response activities and actively identify opportunities to work together. This would include interagency joint site visits to oversee program implementation and progress and joint strategic planning and reporting on future GBV activities.

The team recommends that the proposed USAID Gender Advisor and the CDC Gender Specialist work with colleagues to ensure that PEPFAR GBV programming as well other GBV programming across USG is carried out in a coordinated manner. Until the Gender positions are filled, the country team should ensure that the momentum in support of this work is maintained and that the efforts are shepherded by USG colleagues, in particular the Prevention Technical Working Group.

USG staff

In order to enhance coordination, to lead efforts to strengthen USG GBV prevention and response, and to increase attention to gender across the USG portfolio, the team recommends hiring a permanent USAID/South Africa Gender Advisor, to cover a variety of gender issues, but with an emphasis on GBV. The scope of the USAID Gender Advisor should complement that of the CDC gender position if and when it is filled.

The roles and responsibilities of the Gender Advisor should include: 1) assess level of GBV work in implementing partners; 2) provide training on gender and related GBV issues for USG staff and partners; 3) assist implementing partners to integrate gender further in their programming, build consistency in

messages and ensure quality of content; 4) facilitate use of existing resources and research to inform evidence based GBV specific programming; 5) assist partners to align their GBV work with SAG policies and programs; 6) serve as a USG liaison with SAG on GBV; 7) convene partners, donors and other stakeholders to foster information sharing and collaboration; 8) lead and oversee USG coordination efforts with SAG and between SAG and civil society; and 9) ensure new GBV research and data are communicated between CSO and government and identify what research is needed.

Sources

[1] Genderlinks, Gender and Media Progress Report. Chapter 5, p. 52. Accessed 6 April, 2011. http://www.genderlinks.org.za/article/gender-and-media-progress-study-south-africa-2010-12-17

[2] South African Police Service. (2009/10). Crime Situation in South Africa. Accessed 7 March 2011 http://www.saps.gov.za/saps_profile/strategic_framework/annual_report/2009_2010/3_crime_situation.pdf

[3] Medical Research Council and Genderlinks (2011). The War At Home. Preliminary Findings of the Gauteng Gender Violence Prevalence Study. http://www.mrc.ac.za/gender/gbvthewar.pdf

[4] Abrahams N, Jewkes R, Martin LJ, Matthews S, Lombard C, Vetten L. (2009) Mortality of women from intimate partner violence in South Africa: a national epidemiological study: Journal of Violence and Victims 24(4) 546 -556.

[5] Meeting with Advocate Thoko Majokweni on Feb 4, 2011, Director of the Sexual Offenses and Community Affairs unit of the National Prosecuting Authority, South African Government.

[6] Dunkle KL, Jewkes RK, Brown HC, Gray GE, *et al*. (2004) Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. The Lancet. 363(9419):1415-1421.

[7] MRC (2010). Preventing rape and violence in South Africa: Call for leadership in a new agenda for action. Accessed 18 Jan 2011. http://www.mrc.ac.za/gender/prev_rapedd041209.pdf

[8] Matthews S, Abrahams N, Martin L, *et al*. (2004). *Every six hours a woman is killed by her intimate partner: a national study of female homicide in South Africa. MRC Policy Brief 2004 [accessed 6 June 2007];5. Online at: http://www.mrc.ac.za/policybriefs/woman.pdf*

[9] South African Police Service. (2009/10). Crime Situation in South Africa. Accessed 7 March 2011 http://www.saps.gov.za/saps_profile/strategic_framework/annual_report/2009_2010/3_crime_situation.pdf

[10] Medical Research Council and Genderlinks (2011). The War At Home. Preliminary Findings of the Gauteng Gender Violence Prevalence Study.

[11] Medical Research Council and Genderlinks (2011). The War At Home. Preliminary Findings of the Gauteng Gender Violence Prevalence Study. http://www.mrc.ac.za/gender/gbvthewar.pdf

[12] Maharaj P, Munthree C. (2007). Coerced first sexual intercourse and selected reproductive health outcomes among young women in KwaZulu Natal. *South Africa J Biosoc Sci.* 39(2):231-244.

[13] Economic abuse includes taking earnings, preventing a woman from earning money, selling household goods, spending money on a girlfriend or alcohol instead of the family, or not providing money for household/children's expenses.

[14] Medical Research Council and Genderlinks (2011). The War At Home. Preliminary Findings of the Gauteng Gender Violence Prevalence Study. http://www.mrc.ac.za/gender/gbvthewar.pdf

[15] MRC (2010). Preventing rape and violence in South Africa: Call for leadership in new agenda for action. Accessed 18 Jan 2011, http://www.mrc.ac.za/gender/prev_rapedd041209.pdf

[16] Wilkinson RG, Kawachi I, Kennedy BP. Mortality, the social environment, crime and violence. Soc Health Illness 1998: 20: 578 -597

[17] Wilkinson RG, Kawachi I, Kennedy BP. Mortality, the social environment, crime and violence. Soc Health Illness 1998: 20: 578 -597

[18] UNICEF South Africa. " Gender based Violence" Accessed 09/11/2010. http://www.unicef.org/southafrica/hiv_aids_729.html

[19] Stats SA (2011). "P0211 - Quarterly Labour Force Survey (QLFS), 1st Quarter 2011." Accessed 27 July, 2011. http://www.statssa.gov.za/publications/statsdownload.asp?PPN=P0211&SCH=4910

[20] Shisana O, *et al*. (2009). South African National HIV prevalence, incidence, behaviour and communication survey 2008: A turning tide among teenagers? Cape Town: HSRC Press

[21] Dunkle KL, Jewkes RK, Brown HC, Gray GE, *et al*. (2004) Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. The Lancet. 363(9419):1415-1421.
[22] MRC (2010). Preventing rape and violence in South Africa. Call for leadership in new agenda for action.
[23] UNICEF South Africa. "Gender-based Violence." Accessed 09/11/2010. http://www.unicef.org/southafrica/hiv_aids_729.html
[24] *Ibid*
[25] Mathews S, Abrahams N, Jewkes R *et al* Alcohol use and its role in female homicides in the Western Cape, South Africa. J Stud Alcohol Drugs 2009; 70(3): 321-327
[26] Dunkle KL, Jewkes RK, Brown HC *et al*. (2004) Gender-Based Violence, Relationship Power and Risk of Prevalent HIV Infection among Women Attending Antenatal Clinics in Soweto, South Africa. Lancet 2004; 363: 1415–1421
[27] Rees, H and Chersich M. (2008). "Priority Health Interventions for Reducing Women's Biomedical Vulnerability to HIV inFection in Southern Africa. University of Witwatersrand, Reproductive Health and HIV Research Unit.
[28] Peden MM.Butchart A.Chapter 24: trauma and injury. In: Crisp N. Ntuli A. South African Health Review 199. Durban: Health Systems Trust. 1999: 331-344.
[29] Krug EG, Dahlberg LL, Merci JA, Zwi AB, Lozano R, eds. World health report on violence and health. Geneva: WorldHealth Organization, 2002
[30] Rees, H and Chersich M. (2008). "Priority Health Interventions for Reducing Women's Biomedical Vulnerability to HIV inFection in Southern Africa. University of Witwatersrand, Reproductive Health and HIV Research Unit.
[31] MRC (2010). Preventing rape and violence in South Africa: Call for leadership in a new agenda for action. Accessed 18 Jan 2011. http://www.mrc.ac.za/gender/prev_rapedd041209.pdf
[32] Vetten L, Jewkes R, Fuller R *et al*. (2008). Tracking Justice: The Attrition of Rape Cases Through the Criminal Justice System in Gauteng. Johannesburg: Tshwaranang Legal Advocacy Center, 2008.
[33] Meeting with Advocate Thoko Majokweni,on Feb 4, 2011 Director of the Sexual Offenses and Community Affairs unit of the National Prosecuting Authority, South African Government.
[34] Meeting with Childline on Feb 9, 2011
[35] South African Police Services. The Crime Situation in South Africa, 2009/2010. Accessed March 2011. http://www.saps.gov.za/saps_profile/strategic_framework/annual_report/2009_2010/3_crime_situation.pdf
[36] Dunkle KL, Jewkes RK, Brown HC *et al*. (2004) Gender-Based Violence, Relationship Power and Risk of Prevalent HIV Infection
[37] *Ibid*
[38] *Ibid*
[39] Jewkes R, Dunkle K, Nduna M *et al*. Associations between childhood adversity and depression, substance abuse & HIV & HSV2 in rural South African youth. Child Abuse and Neglect (in press)
[40] Meeting with Pop Council on Feb 9, 2011.
[41] http://www.unfpa.org/public/site/global/lang/en/pid/1167
[42] MRC (2010). Preventing rape and violence in South Africa: Call for leadership in a new agenda for action. Accessed 18 Jan 2011. http://www.mrc.ac.za/gender/prev_rapedd041209.pdf
[43] Medical Research Council and Gender Links. (2010). What is the primary driver of rape in South Africa? What can be done to eliminate it?
[44] DOJCD (2003). Equality Act. Accessed 27 July, 2011. http://www.justice.gov.za/brochure/2003_eqc_brochure.pdf
[45] The Sexual Offences and and Related Matters Amendment Act, 2007 (Act No. 32 of 2007).
[46] South Africa National Department of Health. (2005) HIV and AIDS and STI: Strategic Plan for South Africa 2007-2011. Accessed 11 Jan 2011. http://www.doh.gov.za/docs/misc/stratplan/2007-2011/part1.pdf
[47] South African National Department of Health. (2002). Gender Policy Guidelines for the Public Health Sector. Accessed 07 January 2011. http://www.doh.gov.za/docs/misc/stratplan-f.html
[48] Department of Health (2002). Gender Policy Guidelines for the Health Sector. http://www.doh.gov.za/docs/factsheets/guidelines/gender/chap1.pdf
[49] SAPS Presentation by Logan Govender, Gender Based Violence and Victim Empowerment, Division of Visible Policing, at the Department of Health meeting on GBV, 3 March 2011.
[50] Sigsworth, Romi. (2009). Center for the Study of Violence and Reconciliation (2010). Anyone Can Be A Rapist. Overview of Sexual Violence in South Africa. http://www.csvr.org.za/images/docs/sexualviolence.pdf
[51] South African Police Service. (2009/10) Crime Situation in South Africa. p11. Accessed 7 March, 2011. http://www.saps.gov.za/saps_profile/strategic_framework/annual_report/2009_2010/3_crime_situation.pdf

[52] *Ibid*
[53] National Department of Health, GBV Meeting March 18th, Pretoria, South Africa.
[54] Medical Research Council and Genderlinks (2011). The War At Home. Preliminary Findings of the Gauteng Gender Violence Prevalence Study. http://www.mrc.ac.za/gender/gbvthewar.pdf
[55] Site visit and discussion with GBV survivors at the Wentworth Organization for Women, KZN.
[56] Abrahams N, Jewkes R, Martin LJ, Matthews S, Lombard C, Vetten L. (2009) Mortality of women from intimate partner violence in South Africa: a national epidemiological study: Journal of Violence and Victims 24(4) 546 -556.
[57] Masimanyane Women's Support Center. (1999). Violence Against Women. An Exploratory Study of the Impact on the Justice System on Survivors/Survivors of Domestic Violence and Rape. East London, South Africa.
[58] Andrew Miti, AIDS Foundation of South Africa, presentation during GBV Researcher Roundtable, 9 February, 2011. Police form obtained from staff at Addington Hospital Crisis Center, Durban, KZN.
[59] Population Council. (2011). Presentation: Improving Access and Delivery of Comprehensive Post-Exposure Prophylaxis (PEP) for Sexual Assault (adults and children) and Occupational PEP.
[60] Dunkle KL, Jewkes RK, Brown HC *et al*. (2004) Gender-Based Violence, Relationship Power and Risk of Prevalent HIV Infection among Women Attending Antenatal Clinics in Soweto, South Africa. Lancet; 363: 1415–1421.
[61] Jewkes R, Dunkle K, Nduna M *et al*. (2010). Associations between childhood adversity and depression, substance abuse & HIV & HSV2 in rural South African youth. Child Abuse and Neglect.Nov;34(11):833-4
[62] Provincial Consultation on the DWCPD's Gender Equity Bill, 16 May, 2011, organized by Women and Farms, REACH and the Western Cape Network on Violence Against Women.
[63] Amendment of section 212 of Act 51 of 1977, item 4. The Presidency, South African Government (Oct. 2010). Government Gazette, Vol 544, No. 33607. Accessed 7 March, 2011. http://www.justice.gov.za/legislation/acts/2010-006.pdf
[64] National Department of Health, GBV Meeting March 18th, Pretoria, South Africa.
[65] http://www.unfpa.org/public/site/global/lang/en/pid/1167
[66] Jewkes R, Abrahams N. (2002). The epidemiology of rape and sexual coercion in South Africa: an overview. *Soc Sci Med* 55:153-166.a
[67] Site visit and discussion with rape care health service providers at Addington Hospital Rape Crisis Center, Durban, KZN.
[68] Site visit and discussion with GBV survivors at the Wentworth Organization for Women.
[69] www.lulekisizwe.com
[70] Change.org News. (15 March, 2011). "Corrective Rape Campaign Dominates the Press." http://news.change.org/stories/corrective-rape-campaign-dominates-the-press
[71] Discussion with civil society organizations at the Western Cape Provincial Consultation on the DWCPD's Gender Equity Bill, Cape Town, 12 May, 2011. Held by Heinrich Boell Stiftung Foundation, organized by Women on Farms, Reach and the Western Cape Network on Violence Against Women.
[72] IRIN News (by the UN Office for the Coordination of Humanitarian Affairs). (March 28, 2011) "South Africa: decriminalizing sex work only half the battle." http://www.irinnews.org/Report.aspx?ReportId=84621
[73] Coordinated by the Sex Work Education and Advocacy Taskforce (SWEAT) in Cape Town, http://www.sweat.org.za.
[74] $43 USD
[75] IRIN News (by the UN Office for the Coordination of Humanitarian Affairs). (March 28, 2011) "South Africa: decriminalizing sex work only half the battle." http://www.irinnews.org/Report.aspx?ReportId=84621
[76] *Ibid*
[77] SWEAT, http://www.sweat.org.za/index.php?option=com_k2&view=item&id=66:police-assault-sex-workers-and-get-caught-red-handed-taking-money-from-sex-worker&Itemid=136
[78] Parry C, *et al* (2008). Rapid Assessment of HIV Risk Behavior in Drug Using Sex Workers in Three Cities in South Africa. *AIDS Behav*. 13:849-859.
[79] Van Loggerenberg F, *et al* (2008). Establishing a cohort at high risk of HIV infection in South Africa: challenges and experiences of the CAPRISA 002 acute infection study. *PLoS One*. 3(4):e1954.
[80] Sigsworth, Romi. (2009). Center for the Study of Violence and Reconciliation (2010). Anyone Can Be A Rapist. Overview of Sexual Violence in South Africa. http://www.csvr.org.za/images/docs/sexualviolence.pdf
[81] $28
[82] $6-$10 USD
[83] $21-$28 USD

[84] Vetten L, Kim J, Ntlemo E, Mokwena L. (2009). From Paper to Practice: Lessons in the Implementation of Health and Victim Empowerment Policy Applicable to Rape Survivors. Medical Research Council. Accessed 20 July, 2011. http://www.shukumisa.org.za/wp-content/uploads/2010/11/PolicyBriefRapeSurvivors_LR.pdf

[85] USAID (2007). 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. Accessed 11 April, 2011. http://sa.usaid.gov/south_africa/sites/south_africa/files/FINAL%20REPORT%20ON%20GAP%20ANALYSIS_0.pdf

[86] Christofides N, Webster N, Jewkes R, Penn-Kekana L, Martin L, Abrahams N, Kim J. (2003). The state of Sexual Assault Services in South Africa: Findings from a Situational Analysis of Services. Accessed 20 July, 2011. http://www.mrc.ac.za/gender/sexualassault.pdf