End it now! Together in response to GBV and HIV

REPORT FROM THE NATIONAL GBV CONFERENCE: OCTOBER 2017

AIDS Foundation South Africa
The Global Fund
NACOSA
END IT NOW! TOGETHER IN RESPONSE TO GBV & HIV: REPORT FROM THE CONFERENCE

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End it now!
Together in response to GBV and HIV

Conference tracks

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<td>24 – 26 October 2017</td>
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<tr>
<th>Venue</th>
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<td><strong>Day 3:</strong> Claudia Lopes, Heinrich Böll Foundation Southern Africa &amp; Zarina Majiet, MOSAIC</td>
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Acronyms

ADAPT  Agisanang Domestic Abuse Prevention and Training
AFSA  AIDS Foundation of South Africa
AIDS  Acquired Immune Deficiency Syndrome
ART  Antiretroviral Treatment
CEDAW  UN Committee on the Elimination of all forms of Violence against Women
CHC  Community Health Care
CJS  Criminal Justice System
CSO  Civil Society Organisation
CSVR  Centre for the Study of Violence and Reconciliation
CT  Cape Town
DCS  Department of Correctional Services
DOE  Department of Education
DOH  Department of Health
DOJ  Department of Justice
DREAMS  Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe
DSD  Department of Social Development
DVA  Domestic Violence Act
DV  Domestic Violence
EU  European Union
FPD  Foundation for Professional Development
FSW  Female Sex Worker
GBV  Gender-based Violence
GRIP  Greater Rape Intervention Project
HBF  Heinrich Böll Foundation Southern Africa
HCW  Health Care Worker
HIC  High Income Country
HIV  Human Immunodeficiency Virus
HTS  HIV Testing Services
ID  Identity Document
IPV  Intimate Partner Violence
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<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tr>
<td>JDI-SA</td>
<td>Just Detention International, South Africa</td>
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<td>KZN</td>
<td>KwaZulu-Natal</td>
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<tr>
<td>LGBTI</td>
<td>Lesbian, Gay, Bisexual, Transsexual, Queer, Intersex</td>
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<td>LMIC</td>
<td>Low and Middle-Income Countries</td>
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<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>MSM</td>
<td>Men who have Sex with Men</td>
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<td>NACOSA</td>
<td>Networking HIV &amp; AIDS Community of Southern Africa</td>
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<td>NDOH</td>
<td>National Department of Health</td>
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<td>NICRO</td>
<td>(South African) National Institute for Crime Prevention and the Reintegration of Offenders</td>
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<td>NPS</td>
<td>National Prosecuting Service</td>
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<td>NPA</td>
<td>National Prosecuting Authority</td>
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<td>NPO</td>
<td>Non-Profit Organisation</td>
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<td>NSP</td>
<td>National Strategic Plan</td>
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<td>PEPFAR</td>
<td>The US President’s Emergency Fund for AIDS Relief</td>
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<td>PLHIV</td>
<td>People Living with HIV</td>
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<td>PO</td>
<td>Police Officer</td>
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<td>POWA</td>
<td>People Opposing Women Abuse</td>
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<td>PEP</td>
<td>Post-Exposure Prophylaxis</td>
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<td>PrEP</td>
<td>Pre-Exposure Prophylaxis</td>
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<td>PTSD</td>
<td>Post Traumatic Stress Disorder</td>
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<td>RDS</td>
<td>Respondent Driven Sampling</td>
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<td>RJ</td>
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<td>RL</td>
<td>Religious Leaders</td>
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<td>SA</td>
<td>South Africa</td>
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<td>SAFFI</td>
<td>South African Faith and Family Institute</td>
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<td>SANAC</td>
<td>South African National AIDS Council</td>
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<td>SAPS</td>
<td>South African Police Service</td>
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<td>SOCA</td>
<td>(National Prosecuting Authority’s) Sexual Offences and Community Affairs</td>
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<td>SGB</td>
<td>School Governing Body</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>SGBV</td>
<td>Sexual Gender-based Violence</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>SW</td>
<td>Social Worker (context driven)</td>
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<tr>
<td>SW</td>
<td>Sex Worker (context driven)</td>
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<td>SWEAT</td>
<td>Sex Worker Education and Advocacy Task Force</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>TCC</td>
<td>Thuthuzela Care Centres</td>
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<td>TG</td>
<td>Transgender</td>
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<td>TVEP</td>
<td>Thohoyandou Victim Empowerment Programme</td>
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<td>TVET</td>
<td>Technical and Vocational Education and Training</td>
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<td>UKZN</td>
<td>University of KwaZulu-Natal</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>UWC</td>
<td>University of the Western Cape</td>
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<td>VAW</td>
<td>Violence Against Women</td>
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<td>VAWG</td>
<td>Violence Against Women and Girls</td>
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<td>VEP</td>
<td>Victim Empowerment Programme</td>
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<td>WC</td>
<td>Western Cape</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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<td>WIP</td>
<td>Work in Progress</td>
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<td>WISER</td>
<td>Wits Institute for Social and Economic Research</td>
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<td>WITS</td>
<td>University of the Witwatersrand</td>
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<td>WRHI</td>
<td>Wits Reproductive Health and HIV Institute</td>
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Conference Evaluation
Welcome and Opening Remarks

Joyous Choir, Ekhupoleni Mental Health & Trauma Centre, some of whose members were also delegates to the conference, opened with the singing of the national anthem, joined by the delegates.

The programme directors advised of changes to the programme, thanked the choir and made certain housekeeping arrangements.

Caroline Wills of NACOSA, deputised for Dr Maureen van Wyk who unfortunately could not attend the opening day. She greeted delegates, welcomed all on behalf of NACOSA and AFSA. She delivered the opening address from Dr Maureen Van Wyk, NACOSA to the #enditnow conference.

Dr Maureen Van Wyk, NACOSA as read by Caroline Wills

Good morning and welcome to the #enditnow conference.

On behalf of NACOSA, I would like to welcome organisations, foundations, activists, academics, and government who have come together over the next three days to learn, share, and network around the common goal of ending GBV.

We hope this conference will help to build the momentum towards a more urgent national response to gender-based violence and that it helps highlight the links between GBV and HIV.

The Gender Based Violence Programme, funded by the Global Fund and implemented by NACOSA and AFSA, acknowledges the importance of both prevention and response, as well as the intersections between GBV, young women and girls, sex workers, the LGBTI community and HIV.

Thanks must go to the Global Fund for giving us this opportunity to gain a deeper understanding of the local context, share good practices and raise the voices of those most affected.

Thanks also, to our fellow principal recipients, AFSA, for working with us to make this conference a reality.

The #enditnow conference is unique in that it is a collaborative, local, civil society-led initiative. It is a chance to really get to grips with the challenges and opportunities in the GBV and HIV field – from the ground up.
As a network, NACOSA is all about learning and sharing, so all are encouraged to get onto social media over the next few days and share insights with those who could not be here. Use the hashtag #enditnow (which was displayed on the screen).

Note-takers and a photographer will be recording over the next three days – the hope is to create a rich document of the learning from this conference using the notes, social media activity, video and photography and an evaluation. This document will be shared on the #enditnow website after the conference.

So please, raise your voices and make yourself heard! Let's find a way to #enditnow, together.

All delegates were urged not to hesitate to let the conference know what they want to share, in order for everyone to learn from one another.

**Phumelele Ngcobo, AFSA**

Valencia Farmer was 14 years old when she was brutally gang-raped and murdered in 1999. She was stabbed 53 times. Her killer was only sentenced for the crime 17 years later.

Sihle Sikoli was 19 years old and some men didn’t like that fact that she was a lesbian. So, they stabbed her to death with a spear.

Anene Booysen was gang raped and disembowelled in 2013. Less than a month later the athlete Oscar Pistorius shot and killed Reeva Steenkamp through a closed toilet door.

In May 2017 Karabo Mokoena became the latest face of South Africa’s gender-based violence epidemic. She was killed, and her body burned beyond recognition, allegedly by her boyfriend.

The legendary late Nelson Mandela said that ‘…freedom cannot be achieved unless the women have been emancipated from all forms of oppression.’

Welcome to the AFSA/NACOSA GBV conference themed #enditnow – together in response to GBV and HIV.

Ms Rebaone Petlele, SANAC; Lisa Vetten, WISER; Claudia Lopez, Heinrich Böll Foundation; Shukumisa Coalition; Stop Gender Violence Campaign; Hasina Subedar, NDOH but also all representatives from government, colleagues, guests and all delegates, were welcomed.
Ms Ngcobo addressed the conference saying

‘Dear delegates, welcome to the conference. It is an honour and great joy for me to be in this assembly where people from diverse professional and geographic backgrounds are gathered to focus on one objective: to put an end to the scourge of gender based violence and HIV in our country.’

South Africa still faces the challenge of very high levels of new HIV infections. This means that whilst gains have been made with the treatment and care of people who are HIV positive, policy or programmatic interventions around preventing HIV in the first place remain a challenge. Poverty is still rampant across South Africa and development challenges and HIV continue to fan one another. South Africa’s GINI co-efficient index measure is 67.4 which makes the country the second most unequal society in the world. Similarly, South Africa has highly developed legal and administrative systems to promote gender equality, and yet patriarchy is entrenched and there are persistently high levels of sexual and gender-based violence.

The double epidemic of HIV/AIDS and sexual violence continues to undermine the many gains since the transformation to democracy in 1994. Gender inequality and GBV drive HIV while in turn the stigma of HIV and the impact of AIDS fuels GBV.

AFSA and NACOSA’s GBV partners, the Shukumisa Coalition, together with AFSA’s Culture and Health, and Sexual and Reproductive Health Rights programmes, have demonstrated the complex web of individual, communal and environmental factors which influence the decisions people make about their health and well-being. Perceptions of risk are shaped by a wide range of threats to the health and livelihoods of vulnerable people. For example, many women tolerate abusive relationships with full knowledge of their high risk of exposure to HIV, due to their economic dependency or fear of violence or social exclusion. In their culture they are told ‘umfazi oqotho uyabekezela’

Leaving an abusive relationship is a sign of weakness and failure. Social attitudes reinforce notions of masculinity tied to domination, sexual conquest and risk-taking. The attitudes that fuel GBV are inculcated in infancy, strengthened by the experience that violence goes unseen, unreported and, even when exposed, unpunished. Prevention messages need to understand and challenge these realities.

Violence against women and the unequal power it reflects between men and women is one of the root causes of the rapid spread of HIV in South Africa. Gender inequality is pervasive in many communities across the country and women are still widely viewed as subordinate to men and the less able to exercise their decision-making rights regarding sexual behaviour and risks of HIV.

1 World Bank 2011
South Africa is known as the ‘rape capital’ of the world, a view supported by the statistics on reported rape, unreported rape and conviction rates. Up to half of all women in South Africa will be raped in their lifetimes and more than a third of men admit to having raped at least once. The proportion of adult men from the general population who have raped is estimated at 28 – 36% while 7 – 9% have participated in multiple-perpetrator rape.²

While transformation of attitudes, behaviour and systems is essential to reduce GBV and sexual violence, the current level of sexual violence is so high and the conviction rate so low – at around 7% - that urgent measures are needed to ensure that perpetrators are apprehended and effectively prosecuted. There are many barriers to justice for the survivors of rape and sexual violence, including a lack of an efficient forensic resting system and delays and blockages in the criminal justice system.

Government, civil society and donors were called upon to recognise the importance of extending and strengthening preventive, therapeutic and restorative responses to GBV and HIV and they call upon duty bearers to secure justice for survivors and accountability of perpetrators.

She thanked the Global Fund for the support which has made this conference possible and the delegates for being there to prove that the end to GBV and HIV can be achieved. She also thanked the conference organisers and Conference Call and all of those who directly and indirectly contributed to the organisation of this conference.

The programme director thanked Phumelele for her beautiful opening remarks and commented that all need to denounce victim blaming. The remarks set the tone for the morning’s discussions.

Intimate partner violence (IPV), defined as the experience of “physical, sexual or psychological harm by a current or former partner or spouse” is a significant public health and human rights problem across the globe and in South Africa. In a nationally representative study on IPV, one in three South African women had experienced physical IPV at some point in their current relationship. According to a policy brief on intimate partner violence by Stellenbosch University, South Africa has the highest rate of women killed by their intimate partner in the world – half of all women who are killed in South Africa are killed by their intimate partners.

There is good evidence that intimate partner violence is part of a vicious cycle with HIV, mental illness, poor reproductive health, poor childhood development and chronic disease, and leads to injury, disability and in some cases death. Abused women are twice as likely as non-abused women to report physical and mental health problems and violence in the home has documented negative impacts on the lives of the children in these homes.

Significantly for South Africa, which has the largest HIV burden in the world, women with violent or controlling male partners are at increased risk of HIV infection. Women who experience IPV are more likely to become HIV positive and to get other sexually transmitted infections and the rate of IPV among HIV-positive women is double the national rate. Women in relationships with violence have four times the risk for contracting STIs, including HIV, compared to women in relationships without violence.
DESCRIPTION

NACOSA’s Intimate Partner Violence programme, funded by the Global Fund, provides counselling services through supervised social auxiliary workers to victims of IPV between the ages of 14 and 64. Victims access the service by visiting the offices of the organisations running the service and through outreach using the “go and fetch” principle at clinics, police stations, courts and in schools. They are screened for IPV using 9 simple questions in a standardized tool. The counsellors talk to victims about the risk of HIV, STIs and TB, offer HIV testing, provide condoms and talk about contraception. They then link people to longer-term counselling and other forms of support. The programme will reach almost 90,000 people over three years with 54 social auxiliary workers, seven supervisory social workers working in seven community organisations in the Western Cape, Eastern Cape and Gauteng. At least 80% of the clients will receive HIV Testing Services.

Recognising that this kind of support for victims is only part of the solution, NACOSA also manages an economic empowerment intervention in domestic violence shelters. Four organisations provide between eight and 12 sessions per quarter to shelter residents, former shelter residents and women referred through the IPV programme (where economic abuse has been identified). The women are provided with practical craft skills along with business skills, job readiness support and basic financial literacy to support them to become economically independent. This intensive intervention will reach 1,560 women over three years. At least 60% of these women will receive an HIV test.
KEY LEARNINGS AND RECOMMENDATIONS

Throughout the first year of this programme, we have been struck by the age group that are being positively screened for IPV. Over 30% are young women and girls between 14 and 24 and 29% are women between 25 and 40 years. This correlates strongly with HIV incidence – women in these age groups are considerably more risk of becoming HIV positive.

Organisations running the programme have noticed that there is still significant stigma involved in getting an HIV test at clinics, particularly for people experiencing intimate partner violence, and women report their partners being reluctant to come in for testing. For this reason, it is essential that more social auxiliary workers are trained and certified to provide HIV testing services themselves so that they can test people immediately in the first counselling session. Health officials at clinics also need to make sure they are youth-friendly, non-judgemental spaces where young women at risk can get access to the full range of sexual and reproductive health services.

Each social auxiliary worker must reach three new clients and meet three follow-up clients each working day – a heavy burden on these workers, who need extensive supportive supervision. They also need regular debriefing because the level of violence that they are seeing is traumatisising. High numbers of positive HIV tests are also negatively affecting them. In general, we must find ways of dealing better with mental health issues within the IPV response – greater therapeutic interventions are needed to address the significant mental health issues we are seeing in victims of IPV and their children.

From the available evidence, multi-level interventions work better than single level interventions and current IPV programming operates largely at the response level. Doing more to generate awareness of the available services, so that people can seek help earlier, will help to boost the prevention side of the equation. There is also a piece of the puzzle missing. The role of the private sector in responding to and addressing IPV should be boosted: companies that include IPV screening and referral to services in their workplace wellness programmes, for example, could have a significant impact on the IPV issue.
Notes on PowerPoint Presentation – Sharon Kouta

The following notes were made on each slide, only where additional comments and discussions took place:

Slide 2

The WHO definition (see slide) is used and this is important because this programme is funded by the Global Fund and statistics extracted and commented on are in terms of the programme statistics.

It is important to highlight that sexual violence includes so-called ‘marital rape’.

Slide 3

How big is the problem?

Every six hours a woman is killed by an intimate partner in SA according to the most recent statistics available.

Slide 4

Who does it affect?

Violence does not necessarily start with pregnancy although that is often what they hear. They must also be aware that IPV does not exclude men or the LGBTI community. It is a human rights issue that transcends classifications.

Slide 5

Links between IPV and HIV

This slide shows the vicious cycle within IPV and GBV. Phumelele in her opening remarks referred to statistics and the scourge in SA of the dual impact of HIV and GBV. IPV is included in this. SA has an extremely high HIV burden.

Slide 8

Responses and learnings – Basket of services available

The numbers on this slide refer to the numbers AFSA and NACOSA are responsible for over a three-year funding cycle, in terms of the funding from the Global Fund.

The numbers for women in shelters is not just shelter residents but includes women who are experiencing economic abuse. 60% receive an HIV test.

80% of rape survivors will receive an HIV test and 60% of victims of IPV will receive a test. The organisation is also tasked with doing TB screening.
Slide 9

Who is targeted?
Each social worker (SW) must reach 680 clients a year and provide 4-6 sessions to each client.

HTS counsellors also support the auxiliary SW and SW.

Some of the statistics may show a late start as initially the research focussed on and reached a broader group of GBV clients. The programme is now focussed on IPV. The research also reviews statistics regularly and reconsiders the target groups as the data becomes available.

Slide 10

Graph – red is the TARGET

Slide 13

Lesson 2
Clients are found by going into the community - the clinics, NGOs, police. They do not wait for the clients to come to find them. They know that they will not reach clients by being passive, and they must be active within the community, for credibility and sustainability.

Slide 14

Lesson 3
This is the screening tool and gives an idea of what people are screened for. Often, it becomes clear that the person is a victim of IPV in the middle of the screening for other issues such as TB or HIV

Slide 15

Integrated Health Services – these are crucial lessons to learn to ensure better delivery of services and successful referrals of clients.

Slide 16

Numbers – the first ‘quarter’ began on the 1st April 2016 and the sixth quarter ended in September 2017, 18 months later.

Sharon ended her presentation by saying that these findings were some of the lessons from the programme study that they wanted to share with the conference.

The programme director encouraged everyone to make notes of questions and comments which they might have and announced that there would be a Q&A session at the end of the plenary.
She Conquers Campaign
Hasina Subedar, National Department of Health

ABSTRACT NOT AVAILABLE

The campaign was launched on 24 June 2016 and the name was a result of a competition among young people. The logo too was developed in consultation with young people and the speaker highlighted that it was a collaborative effort in packaging the campaign. What is the campaign trying to achieve?

Notes on PowerPoint Presentation – Hasina Subedar

Slide 1
One of the biggest problems faced in South Africa is the high HIV rate among young people. Statistics are frightening, and it is a major crisis. It is necessary to start looking at ways to address it. It is important to bear in mind that SA is the world leader in these rates and cannot be proud of this. The critical question to ask, and answer is how to respond?

Slide 2
Statistics exclude people who did not deliver in a health facility and terminations.

Slide 3
Young women are 8 times more vulnerable and accordingly the focus is to reduce the rates in young women.

Slide 4
Drivers of infection rates show a disparity, but the biggest driver is gender-based inequality. Poverty and education are also issues that impact.

Slide 5
How to respond? The campaign was put together using these factors.
Many groups and organisations have been working in the field of HIV and GBV and all feel that their programmes work. It is clear from the continued high HIV rates that not all do. As a collective there is a need to be honest with and focus efforts in areas where there is data to show successes.
Slide 6
Objectives:
It is essential to have data on these statistics, this is the reason for the focus of the approach.

The biological approach of ‘testing and condomise’ has not worked as structural and social barriers have not been addressed, which have a critical impact. Until they are, campaigns will never make a dent in the statistics.

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Slide 8
Transmission model
The study showed that many girls and young women who become infected, are infected by young men who are 6-8 years older. This flies in the face of the generally accepted wisdom that it is far older men who are infecting these girls. It is critically important to understand cycle to develop the interventions to address it.

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Slide 9
Core package of interventions
Experts assisted to develop interventions that are evidence based.

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Slide 10
Achievements in first year?
Colours explained: Yellow is DREAMS and green is GLOBAL FUND, white is other programmes by Global Fund and PEPFAR.

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Slide 11
Phased approach is used.

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Slide 12
GBV intervention does not just look at those already exposed to GBV but also those who may in the future be exposed. Norms changes are what are needed to begin to impact on the epidemic.

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Slide 13
Not one of these districts met the target which is a frightening fact. A targeted approach implies the right area and the right clients, and the reason why the targets were not met must be examined. Is the targeted approach the correct one and how can it be refined?
Slide 14
Condoms are essential in the strategy and decline in their use has been reported.

Slide 16
Under 18 deliveries, only 3 districts reported a decline. It is essential to understand the reason why people are not accessing services.

Slide 17
Reporting - why are people not reporting?

Slide 18
There are 1 million people in these districts, but only 230 000 were reached, less than 25%. It is critical to understand how the young are being targeted, to understand what is not working and why.

Slide 19
Fast track
How to support partners to move at a faster pace?
Groups cannot be working alone or in silos. None should be competing for targets. This will contribute to a loss in clients and impact overall success. For example, in eThekwini the DOH has many partners, including universities, and yet only 10% of students at UKZN had an HIV test. The current approach is not doing this correctly.

Slide 20
Fast track 2
The DOH works at developing a system of coordination for efficiencies - takes services to clients and do not wait for them to come to clinics etc. They increase screening by collaborating and a holistic service delivery. They have developed road maps to services (available electronically on the DOH website) and each group can use the BWise App which they have developed. (this includes a clinic finder.)
Once they have empowered young people to use the services the yield will be better.

Slide 21
Demand for services: These are things they can improve.
If they spread resources through the sector, they will have better results. All partners are encouraged to download and co-brand the she conquers logo.
Slide 22
Dedicates time for young people who resist going into a clinic. They are looking at different models of how they can get all our people to access our services.

Slide 23
This is the package(s) that will be provided. All government departments must look at this. It is a holistic approach.

Slide 24
Key Considerations approach.
Input into mapping programme.

LESSONS LEARNT
Hasina then asked all delegates to please visit the NDOH website and familiarise themselves with the programmes and services, including the She Conquers campaign. She urged all to move away from the ‘us vs them’ attitude and unite with government to work at the crisis together. She thanked everyone for attending and for listening to her, and looked forward to their questions.

The Programme Director thanked Hasina for her presentation and announced that all presentations would be available on a USB stick at the end of the conference.
WE ARE FIXED

Women's vulnerability in South Africa is complex and well documented. Women are subject to violence, oppression, poverty and injustice. Women have poor access to health and other essential and support services, with high exposure and low resilience to HIV, AIDS and other barriers to well-being. The Medical Research Council reports that a woman is killed by her intimate partner every six hours in South Africa. This reflects a ‘culture of violence’ that is part of the post-apartheid legacy and perpetuated by patriarchy. South Africa is suffering an epidemic of violence against women, despite diverse and intensive efforts internationally and nationally, by governments and civil society.

Our paper proposes that transformation from vulnerability to resilience is not only an imperative for sectors overtly focused on the well-being of women, but is essential to the whole country and the world. Women’s upliftment should be leveraged as an opportunity for growth and prosperity across sectors, in the medium and long term. Recent research and donor programmes focused on girls and women demonstrate that intervention for and upliftment of women “multiplies the impact” (USAID) as women invest more in their communities. Women disperse support in their families and communities and are integral to community resilience and development processes. If therefore we seek and articulate the mechanisms that will allow diverse sectors and individuals to without benefit from collective action towards a shared vision of a society where women are healthy, resilient and live their best lives, we can strengthen our core work by building a self-sustaining movement including sectors not traditionally seen as having a role to play.

A progressive approach to development suggests that it is possible to simultaneously achieve transformative objectives while promoting economic...
profitability and growth in commercial sectors. South Africa’s economic future must be built on inclusive strategies that are responsive to both the complexity and vulnerability of women in society and to the need for sustainable business prosperity. This requires a gendered lens yet strategies that will achieve transformation for women and through them as “multipliers”, for sustainable economic growth, should therefore no longer be restricted only to charitable health and violence interventions.

To achieve transformation for women and for South Africa through sustainable growth and resilience, diverse role players must work together to achieve their own mandates through collaborative design and collective action. Collaboration is difficult. Even within the sector, there is often low trust, competition for scarce resources and to be heard amongst a clamour of voices, where many are voiceless.

Our methodology provides a framework for productive inter-sectorial engagement, visioning, effective and sustainable collaboration and partnerships, realistic goal setting and longitudinal self-assessment of shared progress and impact. It is designed to articulate “what it looks like when it’s fixed” for all partners, to the benefit of all participants. We believe that with this support and guidance, all members of our society must be engaged in moving us closer to a shared vision of a better future for all, in which women flourish without fear.

Emma Holtmann, from Fixed works with Dr Barbara Holtmann, her partner, who is probably known to many for her work in social crime prevention. They are partners in a consulting firm which delivers a methodology to support and enable groups of collaborators to embrace and respond collectively to complex social and developmental problems.

The perspective is a ‘big picture’ proposition in response to a sense of isolation that are the troubling feature of IPV and the reason for this. Providing some ideas on how they can tackle these issues, they are about trying to solve complex problems. They have had a detailed and technical look at violence and health that many of you experts will be sharing to develop our ‘big picture’ look at advocacy and activism in this sector.

Notes on PowerPoint Presentation – Emma Holtmann

**Cycle of Oppression of Women and Social Instability**

Women’s vulnerability in South Africa is complex and well documented and they are all aware of it. This image articulates the cycle of oppression of women and social instability. It attempts to express, in one slide, the systemic complexity of women’s vulnerability in South Africa.
Again, here is a look at the familiar cycle of women’s oppression.

- Context in the middle
- Resulting life cycle around the edge, oppression on the right moving over to instability and dependence on the left
- Cycle perpetuates itself
- Cycle of vulnerability and dependence

We cannot necessarily control these factors, but can identify them.

**Breaking the Cycle for Women’s Well-being and Integrated Opportunities**

The proposal is that transformation from vulnerability to resilience is not only an imperative for sectors overtly focused on the well-being of women, but is essential to the whole country and the world. Women's upliftment should furthermore be leveraged as an opportunity for growth and prosperity across sectors, in the medium and long-term.

Recent research and donor programmes focused on girls and women demonstrate that intervention for and upliftment of women ‘multiplies the impact’, as women invest more in their communities. Women disperse support in their families and communities and are integral to community resilience and development processes, to economic and social stability.

In the women’s sector they tend to focus on impact for women, because they are dealing with a marginalised and vulnerable group, and our advocacy is focused on foregrounding women. They could have a broader impact (for women, and to enable a more conducive environment for women) if they allowed a broader set of objectives.

Instead of doing things for and to women, they should be taking the lead in positioning women in a broader systemic context. When intervening for women, to protect human rights and respond to vulnerability, there is a unique opportunity to have a broader impact. So, for example when they intervene for girls in their early childhood, or to curb the abuse of alcohol and consequent domestic abuse of women, they can simultaneously be offering opportunities to unemployed women for pro-social innovation and small business opportunities: for e.g. small local eco businesses or tea shop to replace shebeens.

When intervening to promote safety for women, programmes can include increased mobility as an objective, which in turn enables improved economic participation and productivity for women, which results in local economic stability and growth, and contributes to the eradication of poverty.
Collective action towards a shared society

The sector can build a self-sustaining movement that will achieve transformation for women. No one sector on its own can create a complex vision. They must reach out from our sector to explain the context of each role player. Only if they take collection action can they overcome the complex and multiple problems. If they seek and articulate the mechanisms that will allow diverse sectors and individuals to benefit from collective action towards a shared vision of a prosperous, resilient society, where women are healthy and live their best loves, they can strengthen our core work by building a self-sustaining movement including sectors not traditionally seen as having a role to play. To achieve transformation for women and for all South Africa through sustainable growth and resilience, diverse role players must work together to achieve their own mandates through collaborative design and collective action. They need to be genuinely inclusive and respectful of different sectors and non-negotiables. They are seeking a synergy. This is not something they will achieve in the short or medium terms but is a long-term goal. They propose that articulating the vision can find a way for us to move together to a shared goal and to find each party’s role. A more nuanced approach is required from each role-player.

Collective action: Three sectors

Collective: they have divided society into three sectors for this discussion. Of course, a far more nuanced and inclusive approach to participation is required but for this discussion they will be talking in more general terms.

Business: A progressive approach to development suggests that it is possible to simultaneously achieve transformative objects while promoting economic profitability and growth in commercial sectors. South Africa's economic future must be built on inclusive strategies that are responsive to both the vulnerability of women in society and to the need for sustainable business prosperity.

Civil Society: Aggregate of non-governmental organisations and institutions that manifest the interests and will of citizens, including international non-governmental organisations, the family and the private sphere.

Within these sectors are of course specialised areas of skill and focus, such as women’s well-being (which can span government, business and civil society)

Shared: To be truly inclusive will require compromise. The hierarchical and patriarchal culture of the business sector will have to be influenced by the insights of women’s well-being specialists who will change the very definition of profitability to enrich it to mean something more inclusive and sustainable. This does not mean that business will lose its identity or that women’s well-being specialists will gain supremacy. It means that all participants will be given the opportunity to influence the thinking of others through their own non-negotiables, the core principles of their expertise and experience, while being required to compromise on their own negotiables. This is the most difficult part but means that each party has the chance to influence based on their expertise.
Collaboration is difficult

All three sectors find it challenging to understand the perspective of the other and each has characteristics that make it difficult to collaborate internally and externally.

Business is naturally competitive and driven by patriarchal hierarchies which make it very difficult to speak a language that civil society can understand.

Civil society suffers a culture of scarcity and has limited resources available to achieve limited impact.

Government is constantly plagued by excess of demand for its limited resources and capacities and constantly under the whip of internal and external criticism and complaint about its inability to deliver.

All three sectors find it difficult to understand the perspective of the other; where there is specialised insight and expertise there is arrogance which makes it difficult to compromise around principled issues. There is low mutual understanding and consequently low mutual trust.

Aggressive conflict resolution is a part of our society. Where they differ, they fight, and they do not compromise. Even where they do know they need each other they are inclined to feel hatred and anger rather than compassion and trust. Trust is at the centre of our ability to work together; if they do not believe they have the same objectives at the core of our mandates and our dreams, and place a shared value on those objectives; if they do not believe they can rely on one another to fulfil our respective roles and to be transparent and accountable, then they will never be able to rely on one another.

Proposal/Methodology

This methodical approach suggests that the challenges to achieving sustainable, systemic impact through collective design and collaborative action cannot be ignored. The proposal of this presentation is to promote an approach to women’s well-being which is innovative and unfamiliar to all participants. Where they are currently struggling to achieve sustainable impact, there is little danger in innovating, but innovative approaches cannot simply unfold without careful consideration of all the barriers and challenges to success. Our approach talks about defining what is negotiable and what not; put it on the table and make that clear - what will be a stumbling block and what not. They may be able to determine how they redefine that and then articulate a shared vision. This includes the outcomes of all participants. A methodology must be adopted that allows the sector to embrace the complexity of its objectives and respond to the difficulties of the proposed approach. Using the vision, they can look at specific strategies for interventions, M&E and leading the way. This is how FIXED methodology works. They suggest that there be a principled methodological approach the achieve the aim that should be negotiated and shared for a shared desire for a shared future. The vision becomes central to
building strategies, conducting research through piloting, monitoring progress and re-aligning strategies through learning.

All sectors and programmes are struggling, and work is often lonely and isolating. This approach suggests that it need not be and that they can find solace and gain support through cross-sectoral partnerships, strategies and collaborations.

The programme director thanked Emma for her inspiring look at the possibilities where they can trust each other and find common ground.
A Critical Assessment of the Role of NGOs in the Delivery of Services at TCCs

Shukumisa Coalition

Background

In 2017, the Shukumisa Coalition commissioned a study to better understand the role played by non-governmental organisations (NGOs) who work in Thuthuzela Care Centres (TCCs) and the challenges they face. TCCs are one stop shop facilities that provide medical and forensic services, psychosocial counselling and prosecutorial services to victims of sexual gender based violence (SGBV). They offer an integrated service from emergency trauma care to preparation for court, ideally reducing the overall length of time in finalising cases and improving conviction rates. The psychosocial services are offered by NGOs.

This study forms part of the TCC Monitoring Project based on a partnership between Shukumisa and the Soul City Institute for Social Justice funded by the Foundation for Professional Development (FPD). The project emanated from a report that Shukumisa published in 2015, “It sucks/It’s a wonderful service”: Post-rape care and the micro-politics of institutions. The study, conducted by Lisa Vetten, sought to describe the range of emotional support services provided to rape survivors by NGOs based in TCCs. The study found that two key themes were repeatedly emphasised by organisations in this regard: the funding of their services; and the relationships between the various institutions located within the TCC, and the effect of these on post-rape care.

The Soul City Institute partnered with the Shukumisa Coalition drawing from our community-based monitoring experiences. Shukumisa member organisations were to be trained to conduct the monitoring of TCCs on-site to expand the findings of above mentioned study. However, the scope of the project changed to ensure relevance and fit with other related processes and was revised after a TCC Compliance Audit and Gap analysis report was released by FPD and had covered aspects of the original scope.

The initial idea of the study was to monitor TCCs over the duration of one year and to assess the services it offers with a specific focus on the services offered by NGOs. Eventually the project was carried out over a much shorter period of time. A team of six Shukumisa member organisations providing advice and assistance on how to implement the project decided the study should conduct interviews with Shukumisa members and
other organisations working with or within TCCs, followed by a consultative forum to verify the findings and deliberate on the role played by NGOs. The aim was to establish how the role of NGOs in TCCs can be optimised and to contribute towards improved collaboration at TCCs and services to survivors of sexual violence.

**Interview process and consultative forum**

Data was collected between February and March 2017 from 19 NGOs working in TCCs through in-depth interviews with key informants and a consultative workshop. The sample represented 35% of TCCs purposefully selected based on the following criteria:

- Shukumisa membership
- Geographic spread to ensure proportionality
- TCC in hospital/community setting
- Rural/urban provinces and setting
- NGO working within or outside TCC
- Patient throughput in TCC

Interviews were conducted face to face and telephonically. The respondents were NGO management and some site based social workers. The data was transcribed verbatim and analysed thematically. The 2-day consultative workshop was held with 17 of the 19 organisations that participated in the first phase. The workshop was aimed at enriching the findings from the interview process through focused engagements with NGO representatives and other relevant stakeholders. The workshop format was very interactive, with group sessions, plenary reflections and presentations of other relevant research studies. The workshop produced key recommendations and action points for NGOs, government departments and other stakeholders.

All the organisations that participated in the study offered psychosocial support to all victims presenting at the TCCs. The majority of the cases were sexual assault victims; others included physical and emotional abuse. Some organisations offered and conducted pre- and post-test HIV counselling and adherence counselling and information on PEP.
The findings generally looked at

<table>
<thead>
<tr>
<th>Extent and drivers of SGBV</th>
<th>Barriers to reporting SGBV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Culture of interpersonal violence</td>
<td>Most people do not know their rights</td>
</tr>
<tr>
<td>Patriarchy and gender inequality</td>
<td>There is poor knowledge of the TCCs</td>
</tr>
<tr>
<td>An ineffective and unresponsive criminal justice system</td>
<td>Perceived poor quality services</td>
</tr>
<tr>
<td>Fragmented and ineffective programmes</td>
<td>Protection of perpetrators</td>
</tr>
<tr>
<td>Alcohol and substance abuse</td>
<td>Logistical challenges</td>
</tr>
<tr>
<td>Harmful cultural and religious beliefs</td>
<td>Denial on the part of parents</td>
</tr>
<tr>
<td>Poverty</td>
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While participants perceived the TCC model as a great model that is patient focussed and minimises secondary victimisation, the challenges identified through the interviews and the workshop outweigh the positive outlook.

**Challenges faced in the TCC**

- Long waiting times
- Inadequate working space and other infrastructure and inadequate resourcing
- Poor stakeholder relationships (between the DOH and NGOs)
- Some TCC staff are not always on site
- Lack of accountability
- Administrative challenges
- Poor access to TCCs
- Outdated protocols and protocols not followed
- Different organisations use different counselling models
- Late reporting of cases

One of the crucial challenges are the gaps in policies and protocols as well as the lack of understanding of the policies, the lack of consistency and harmonisation in guidelines and policies and different and wrong interpretation of policies.

Another grey area highlighted in the policy was that of interpretation of exposure to HIV. Currently the law states that any victim of sexual assault exposed to HIV should be offered an HIV test. In some instances, children upon examination did not show any signs of penetration, and this was interpreted to mean that the child had not been exposed to HIV and by implication there was no need for an HIV test. However, this is a narrow interpretation of exposure to HIV, as someone can come into contact...
with semen, blood and vaginal fluids without any penetration. This means that more needs to be done to ensure correct and consistent interpretation of the policies.

Another major challenge is the funding and sustainability of NGO TCC work:

- Funding for psychosocial services in TCC is often fraught with inadequacy and uncertainty
- Government should take responsibility and provide the funding
- Foreign funding, often used by NGOs as supplementary funding has a lot of short comings
- Funding for TCC should cover 24/7 services
- CARA funding should be made more accessible to NGOs
- The NGO rationalisation process is threatening the survival of NGOs and compromising support for sexual assault victims
- Inequity in the salaries for social workers is detrimental to patient care

Successes

The NGOs that participated in the study had a lot to be proud of. They highlighted some of their successes and reflected how, in spite of all the challenges; they had remained committed to providing a quality service to the patient and ensuring that the victims are indeed transformed into survivors.

- One NGO had been offering volunteer services at the TCC for up to 3 years before they received any funding. This was a sign of dedication and commitment to the cause.
- The NGOs had had continuous uninterrupted presence in the TCCs. In spite of funding uncertainty - they would not cut staff, but rather scale back other services in order to ensure that patients are well taken care of.
- Many of the NGO reflected on the foot print they had in the community in which they worked, reflecting on the strong relationship, trust and reputation as advocates for women’s rights and the rights of survivors.
- Some NGOs saw the increase in the number of cases reported as an expression of confidence in the quality of their services.
- Most NGOs cited that they had been successful in securing funding for the TCCs amidst dwindling development funding and reluctance to fund South Africa as a middle-income country.
- Some of the respondents felt that through the work that they did, they had successfully turned victims into survivors, enabling them to reintegrate into school, work and society.
- Most of the NGOs felt that the containment counselling helped manage trauma and that it formed the basis for a smooth experience within the TCC.
• Ability to advocate for the patient – amongst others in terms of language, and access to professional staff.

• Some NGOs felt that the psychosocial support, particularly around court preparation helped achieve quicker trial times and higher conviction rates in those cases that make it to court.

• NGOs were contributing to employment and poverty alleviation in the communities.

• NGOs had collaboratively developed norms and standards for rape survivors in acute stage of trauma. This is the first of its kind and attempts to benchmark services for sexual assault victims.

• Some innovative approaches have been developed such as the buddy system implemented by TVEP and described as a best practice model in the report.

Creating linkages: how can the report influence the role of NGOs in TCCs?

Participants agreed that the TCC model is conceptually a very good model and has huge potential in offering comprehensive services to SGBV victims and significantly reducing secondary trauma. However, in spite of huge efforts by NGOs to offer quality services, especially psychosocial support to victims, their work remains outside the scope of the TCC blueprint. As a result, many gaps remain in the delivery and standardisation of psychosocial care for victims of SGBV. In addition, NGOs are not wholly funded by government. In the face of the continuing epidemic of SGBV, it is time for government to accept their obligation to ensure the financial sustainability of TCCs, and in particular the psychosocial care offered by NGOs.

The workshop established a set of recommendations:

• The SOA should be revised to make psychosocial support imperative for SGBV survivors. This will ensure that any service delivery models, such as the TCCs include the role of NGOs in their blueprint (incl. 24/7 services, without which more than 60% of the victims of reporting to TCCs would not receive a full range of timely service).

• The TCC model has to be revised and costed to ensure greater effectiveness, improved operational efficiency and better patient outcomes.

• The services offered in TCCs should be standardised through valid protocols and guidelines. All TCCs should have signed and up-to-date protocols, which are the basis for the relationship between the different stakeholders.

• In light of the limited number of TCCs – 55 country-wide - government should set up satellite TCCs and cheaper SGBV trauma management models to provide services closer to communities in order to increase access.
• DSD should provide funding for NGOs on a long term contractual basis and take greater ownership of the role played by NGOs through defining and funding core essential services for SGBV victims and debriefing services for care givers.

• DSD should provide clarity on what are considered ‘essential’ services for sexual assault victims to ensure uniform offering at all TCCs and ability for stakeholders to hold each other accountable.

• Government should do more to market the TCCs and create an awareness of their services amongst the general population. There must be increased visibility of signage to the TCCs including the rights of survivors and complaint processes.

In conclusion, NGOs should lobby government to develop a legislative framework to allow for the establishment of TCCs as a formal part of the criminal justice system and putting in place a sustainable funding model for NGOs and TCCs in general.

The Shukumisa Coalition is currently drafting its action plan for 2018/19. One of the goals of Shukumisa’s theme: Strengthening Law and Policy is that Thuthuzela Care Centres have a formal legal framework.

The presentation took the form of an informal and brief discussion of the research by three members of the coalition. There was no PowerPoint presentation and no additional notes on the presentation.

Questions arising out of the first session

The delegates commented:

1. Look at processes of pregnancies in the use of alcoholism. What is the cause of this? Alcohol is a key issue.

2. Protocols – let’s look at what strategies that don’t work, political well, very academic. An integrated method is needed for the young people on the ground.

3. I worked in schools, it is very challenging, you need to write to principal, then to department circuit, the SGB, and then only effectively have 6 months each year. I am not sure if the watchdogs of the DOE know that this work is critical.

4. FIXED model is needed in SA – has it been tested and what are the outcomes?

5. Shukumisa – regarding the relationship with funders – they need to consider where the Government is now. They have a budget deficit and Government probably cannot fund TCCs. They need to include business; how do they link those threads?
6. ‘She conquers’ – what do they do when women just want the violence to stop and they are worrying about reducing the infection rates. If they are talking about this, they cannot not work with men and boys. They must also support programmes that support men as clients, not just perpetrators. This will contribute to reduction in violence. Children grow together, if they empower one side then there is a disparity and that can add to the conflict. If work is focused on girls and their male partners, they need to concentrate on young boys or they will lose them. They are being left out and this becomes a problem.

7. We must start working with boys at primary school level, by high school it is often too late.

8. GBV looks at Gender not just women and girls. Gender fluidity is also a factor that must be included in our programmes – How? RHI also provides services to transgender clients. Boundaries are shifting within society and I want to highlight this.

9. Some quoted stats seem out of date – a woman killed every 6 hours is from 2004 – what are the current stats?

10. Statistics are clear that smart phones are available to everyone. What about online abuse? How do they train people to mitigate against online abuse?

Answers

**Hasina Subedar (She conquers)**

Alcoholism is central in our programme of change. If you look at the different programmatic areas, you will see that substances/abuse are part of the programme.

The programme is not just focused on girls, boys are included. Interventions focus on girls and boys. The name was chosen by young people, not young women.

Looking at older men who normally don’t get tested, our programme does include them.

Gender issues are included in several the programmes – this presentation could not cover all the different interventions. The whole basket is available to all young people. All partners should be implementing the full basket. Lastly, she wanted to stress that they are not about bringing in additional resources, they are bringing people together to achieve a common aim.

**Shukumisa**

**TCC protocols too academic** – Shukumisa can only make recommendations, but they can look at our language and make sure they simplify the language to make sure it is accessible.

**Role of corporates** – they have taken note of this and they must look at it.
Gender fluidity – There is a gap in our membership as only a few organisations that work in this. Members are however aware of these gaps. Our members are the recruiters and they should address these issues.

Emma Holtmann

This method has worked within a range of sectors

Government, corporates and NGOs are constantly evolving in the face of these engagements. They have notable examples of how the method has enabled collaboration and partners are able to influence the partnerships they solicit using the method. It also works in the local context, although it is far more difficult to mobilise across a sector. They have not done that but would love to.

Cyber bullying is so important – they have encountered some excellent partners and respond to the opportunities they receive to facilitate the methods. EG SAVETEEENNET is an area of essential intervention and innovations.

Sharon Koauta

Substance abuse – Main aim of my presentation is to share the lessons learnt while implementing our programme over the last 6 months. They have thought about shelter programme costing using ‘sin taxes’ – given that alcohol is such a large factor, perhaps they should lobby for Government to put them into GBV programmes

Schools and after hours – they encourage organisations to run programmes after hours and to not interrupt the school programme.

Focus on men – There are parallel programmes, ours are not just focused on women.

Statistics – they use the latest statistics available which can be shared with delegates.

Second round of questions and comments

1. Biggest challenge is lack of trust and collaboration. It is 20 years since the NGO Act was passed and it has never been reviewed. The King Report now discusses governance, which is critical and is not covered by the Act. How do they promote funders trust in our organisations? There can be a perception of corruption. What is our role as civil society to promote trust when seeking relationships with funders and donors for the sector?

2. Our role as men – they are not doing enough to challenge the triple challenge. They are about to embark on a campaign to engage men nationally to respond to a men’s movement.

3. Engaging men and boys in their role within civil society. A strategy needs to be piloted nationally.

4. Moving forward they need to think about their role within the sector. They need to advocate to have an independent directorate where they can be separate from Government. Government cannot be a referee, player and spectator. They need veterans in the field to oversee such a directorate.
5. She conquers programme is being rolled out in 3 places – will it be extended to the rest of the country?

6. How is data collected for the programme?

7. M&E – how do they find out if programme is working? Issues relating to civil society shows its key role but there appears to be an increase in GBV and HIV statistics. Where are the gaps?

8. Are they disintegrated as a sector?

9. Have they done enough to influence policy and legislation?

10. Have they met regional and international obligations?

11. How do they move ahead to address GBV?

12. Pointers to infection rates for women and girls is ages 15-23 which is the same entry age for sex trade, which is also coupled with the transactional sex issue. They have agreed that this group is at elevated risk for infection, but they simultaneously call it by a name that glamorises the activities – the exchange of sexual acts for gain. Drivers are poverty, but the structure of patriarchy is a huge factor. They must address the lack of power within this group. These are a group that are continuously oppressed, and they need to empower women – economically, not just through sex work.

13. Concerns are:

   Religion: Have not seen religion mentioned as a factor – pastors are presently excluding LGBTI from churches, and this must be addressed.

   Culture: This was not addressed but is a factor that can promote a system of GBV – and used as an excuse. Need a strategy to counteract this.

14. Emma: Our programme targeted a silent majority which was men who are not involved in GBV – what they have realised that most issues are initiated by men. Once you make them aware there will be better understanding of the problems and the solutions.

**Answers/closing remarks**

Hasina

Transactional relationships happen across the board and they need to look at the drivers of those relationships. When we analysed the root causes of challenges there were poverty, lack of education, and lack of opportunity. They need to be careful not to pass judgement. If you see what a sex worker earns, they will earn very little. It is about mere survival and is usually the only way for these girls to just survive. Poverty is also leading women of all ages to enter sex work as they can no longer survive otherwise. It is essential for us to look for opportunities for women to do other things.
Shukumisa

International obligations are very challenging although it is what they try to do every year. The sector needs to plan and share information. Everyone still works in silos and until they stop, these challenges will remain.

Emma

Cause - the problem is that there is no one cause - it is a complex set of factors - the cycle of oppression. Opportunities to break that cycle come in a variety of ways. Targeting men may be one of the ways to break the cycle but that will not be sufficient as the issues are more complex than just ‘men’.

As civil society they feel isolated and disrespected. They must be honest about our relationships and find a way to step toward the people. All parties need to come together and work in a coordinated way. They need to fund with others. They also need to set this aside when building relationships. Introspections and understanding one another is essential. It is critical that they be transparent about what our joint aims are.

Sharon

NACOSA is implementing IPV services in 6 districts with 7 partners. Funding is challenging, and the Global Fund funding model has now meant that 27 TCC centres lost their funding. Therefore, the programme became a larger basket of services.

M&E – they have very strict requirements and extensive processes to monitor our work and that of our partners.

Religion – this is just the beginning session and other presenters will speak to religion, culture, men and boys during the rest of the conference. She expressed her gratitude for the robust nature of the conversations.

13:00 – 14:00 Lunch
14:00 - 16:30 Plenary

Best Practices in the Real World: What counselling should we provide for rape survivors in South Africa?

Kempie van Rooyen, Psychological Society of South Africa, Trauma and Violence Division

BACKGROUND

South Africa is considered the rape capital of the world and the South African government recognises the human rights of survivors and consequent services required as a comprehensive response to sexual assault. Although counselling services are considered an essential part of this response, the provision of counselling and psychotherapy is not included in the basic services provided directly to survivors of rape by government (explicitly due to cost considerations). This means that these services are often provided on a site-by-site basis by motivated community groups, non-governmental organisations and other service delivery agencies. While these groups and organisations are invaluable in the fight against gender based violence and essential counselling services will collapse without such involvement from civil society, there is no consensus on the kind of counselling assistance that should be provided to rape survivors.

This practice creates great variability in the nature (and possibly the quality) of counselling services that are given to survivors. International best practice guidelines can potentially be used to create greater uniformity and improve overall quality, but there are several problems with simply transporting international guidelines to the South African context. International guidelines are often developed in high resource settings and are appropriate for use by psychologists or highly trained mental health clinicians. These skillsets are often not available
at the rape counselling coalface in South Africa. A task shifting approach has been
applied successfully in other low resource countries to overcome such unavailability
and a similar strategy can be used in the South African rape counselling context.
The uptake of treatment guidelines in systems and contexts do however present
a problem when real world contexts are quite different to those in randomized
controlled trials (or those envisioned by the creators of treatment guidelines). One
such differences that needs to be considered is the pervasiveness of rape (and the
drivers that lead to this pervasiveness) in the South Africa context.

The presentation uses the international best practice models for the counselling of
rape survivors as a departure point, but contextualises this against the counselling
realities in South Africa. It proposes a task shifting and networking approach to
create a framework of practice that considers what reasonably could work and what
reasonably can be delivered by different role players in the South African context.
Proposed practical guidelines in terms of the goals of counselling, the necessary
competencies and skillsets are provided to cover the full range of counselling
services that rape survivors deserve. The purpose of the proposed framework is
intended as a heuristic starting point to facilitate discussion about appropriate
counselling strategies and not as an absolute end.

Kempie is a clinical psychiatrist and has trained many people in trauma counselling,
specifically in Port Elizabeth. He hopes these lessons are applicable within the broader
audience here. Many delegates seem to understand counselling as an essential part
of the rape crisis response.

Notes on PowerPoint Presentation – Kempie van Rooyen

Counselling is essential for rape survivors, but the length and weight given to the
needs and roles of counselling is underplayed in protocols and literature. Often the
counselling is just education – the victim's rights and so on. These are important, but
the focus is often solely on that. Everyone remembers the clients who come back
and tell them that they have changed their lives. That is because it is a personal
connection and experience. I believe it is possible to have more of these. Counselling
is about changing a life. It is an interaction between a counsellor and a client. It is to
humanise a person who has been dehumanised.

Usually counselling happens on a one-to-one basis but it can be as a group. It is a
formalised interaction, recognising that healing takes place in an interaction – thus
counselling may be within a family as well as with an individual, for example.

Most of the information that they have about counselling comes from rape counselling.
Much of what they know about trauma comes from rape survivors. There is not a lot
of research into rape however – to see what they should put into counselling to help the survivor. In terms of best practice there are gaps and additional factors that should be incorporated.

Most of us are trained in supportive counselling and this is helpful but other types of counselling are also very important and useful.

Often these methods were developed in high income countries where the sexual assault is the only thing that people need to deal with. Additionally, they focus on the clinical aspects and ignore the social and social justice experiences. Feminist theories have been excluded probably because they do not focus on clinical aspects.

They cannot use science without context. They cannot just copy these practices directly as they do not fit our environment. Research is highly technical and often luxurious in terms of resources and time allocation. This is not a part of the reality of our environment in SA.

They know for example that they do not need elevated levels of training to be useful to rape survivors and they can do many things in terms of task shifting.

They can also miss important aspects of the real-world scenario. Academia can be context-less which is less useful in our context. They need to incorporate ground level knowledge and work in tandem with academia.

Counselling (particularly in the context of rape) has 3 phases

• Acute/Education/Chronic

If they use this system, it makes counselling effective – this is a suggestion. He would like to emphasise that NACOSA has guidelines for first responders.

At the next level they can include some academic suggestions.

In terms of these suggestions, volunteer counsellors can be assisted by professionals, but you do need additional training and the continued support of a professional (a supervisor) The question then to ask is what additional resources do we need?

Let us consider the example of ongoing therapy – the more you are exposed to something the less frightening it is.

Thus, the suggestion is:

• 1st stage education
• 2nd stage some adapted information and counselling
• 3rd stage more technical but they can still provide some assistance supplemented by a professional

What is not touched on is what they do without testing and recording – experience tells them these suggestions work but they have not considered them yet. They could use the existing science, coupled with what works on the ground to find a system that works for our context.
Understanding the Factors Associated with Intimate Partner Violence Amongst Female Sex Workers in Soweto

Venice Mbowane, Perinatal HIV Research Unit

BACKGROUND

In South Africa sex work is criminalised. This perpetuates increased vulnerability of violence and mental health for female sex workers (FSWs). In Soweto FSWs have a higher HIV prevalence than the general population. Evidence from a Soweto study of women engaging in transactional sex, showed their increased risk of HIV if exposed to IPV. Most studies have focused on police and client violence against FSWs, with little evidence describing exposure to intimate partner violence (IPV). This makes comprehensive intervention development challenging for those working with such key populations. Their study aims to describe IPV experienced by FSWs in Soweto, and to understand associated factors.

METHODOLOGY

They conducted a cross sectional survey using a respondent driven sampling methodology. 508 FSWs were enrolled from Soweto, South Africa between February - September 2016. Both weighted and unweighted RDS data were analysed.

RESULTS

The majority of FSW were born in Gauteng (68%) and KZN (17%) with a median age of 30 years. Over half of FSWs had experienced physical or sexual IPV in the past year (57%), and 65.6% experienced emotional abuse by an intimate partner, 22% of FSWs experienced coercive first sex. The median age for first selling sex was 25 years (6-48). Mean stigma and childhood abuse scores were 9.1 and 19, respectively. Majority of FSWs had a current male partner and 28.9% knew they were selling sex. Partner knowledge and IPV were not significantly related (p=479). HIV prevalence was 53.1%. We found that 90% of FSWs who reported some emotional abuse also experienced

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sexual violence in the past year. The median stigma scores for FSW who experienced IPV in the past year was 9.6 and 19.9 for childhood abuse, respectively. Past year emotional abuse increased the likelihood of physical/sexual IPV by 16.0 times (95% CI 8.23-31.00). External stigma and childhood abuse also increased the likelihood by 1.1 times (95% CI 1.0-1.27, and 95% CI 1.0-1.21, respectively).

FINDINGS
The results show that IPV is not associated with HIV amongst FSWs and IPV is prevalent among sex workers in Soweto. Emotional abuse, external stigma, and childhood abuse had a significant link to IPV. Our findings show the necessity to respond to the needs of FSWs through strengthening programmes that are geared towards challenging norms which perpetuate violence against women and sex workers. Furthermore, findings highlight the importance of reviewing legislation criminalising sex work, which is a driver of discrimination against sex workers, and which is strongly associated with IPV.

Notes on PowerPoint Presentation – Venice Mbowane

Slide 1
This is a bit of a background on the area and the study. Once a woman is exposed to violence, this increases the risk of HIV. Together with this comes mental health issues and substance abuse, which leads to adherence challenges.

Slide 3
Methodology.
The study involved 508 Sex Workers (SW).
Recruitment involved coupons which encouraged SW to bring colleagues to the study. As the system is participant driven, they did need to weight the sample to take this into account. The presentation looks at adjusted results.

Slide 4
Participants screened if they didn’t meet the criteria they would leave the study.

Slide 5
Results: Majority of participants were from Gauteng; the median age was 25. Very few had completed their secondary education. In the transactional section, the partner was usually 6-8 years older.

Slide 6
Childhood trauma: Sexual assault was the main trauma the participants had experienced.
**Slide 7**
Prevalence of violence: Majority had experienced abuse of all kinds.

**Slide 8**
Impact of childhood abuse: The stats refer to the number of abuse incidents the participants have experienced in their lives. The more negative or traumatic childhood abuse, the greater the chance of increased abuse by a partner.

**Slide 9**
Just because a person is a SW or is HIV+ is not a factor in IPV – our figures show that health becomes a last objective of the SW as the primary factor is supporting the family and children. There are not a lot of programmes that equip SW with the power to negotiate the relationship – e.g. the use or not of condoms.

**Video and poem**
After this presentation there was a showing of a video & poem: I have Life (movie trailer) & I am Woman (poem) by Alison Botha, Rape Survivor.


The programme director commented that we can see the struggles women have experienced and why violence must end – we must find a solution to this struggle.
BACKGROUND

Gender-Based Violence (GBV) is today recognized as a serious global health and human rights violation. GBV is pervasive in South African society, is a complex phenomenon and is often seen as the driver of HIV. The consequences of GBV are devastating. GBV and HIV and AIDS are social problems that affect the quality of life and the social functioning of many people including women worldwide. They contribute negatively to the physical, social, emotional and psychological well-being of an individual. Survivors often experience life-long emotional distress, mental health problems and poor reproductive health. Abused women are also at higher risk of acquiring HIV. Both men and women can be perpetrators of violence, but most of the perpetrators of such violence are usually men against women. The impact of violence may also extend to future generations: children who have witnessed abuse, were victims themselves or were born of the abuse suffered by their mothers, can suffer lasting psychological damage. Indeed, there is evidence in research to indicate that the intergenerational transfer of trauma (whereby children who were born after the fact are negatively affected by trauma inherited from their families and communities) is profound within families and communities that have suffered loss or experienced violence and trauma. This again demonstrates the long-lasting impacts and consequences of violence.

NICRO has been working in the field of GBV for over 3 decades and has over the years reviewed and revised its approach in line with global trends in GBV prevention. NICRO believes that a siloed, fragmented approach could be a serious issue in perpetuating gender-based violence and HIV prevention, and that holistic, restorative and coordinated approaches are necessary. Therefore, a
comprehensive and multi-strategy focus is needed. NICRO has found that strategies must include interventions with victims and perpetrators, including interventions with children exposed to the violence. Prevention efforts should occur at the individual, family, community and global levels. There is no one-size fits all approach and the diversity of contexts need to be considered. Structural causes of violence and issues of norms and belief systems, and mobilizing communities in becoming drivers of change also must be addressed, as well as state and civil society working much closer together in partnership, if there is to be a positive social change that is effective and sustainable, and that is able to address GBV and HIV/AIDS.

Over the years NICRO has worked across the spectrum of GBV – from a focus on victims, perpetrators and prevention. On a smaller scale NICRO has also worked with men and women as victims of sexual violence on a counselling basis, including men raped in prison. We also dealt with cases where victims had to deal with the double impact of the trauma of the rape and HIV/AIDS. NICRO has also worked closely with Traditional courts in rural areas on GBV. Other areas of work have included Victim Offender Dialogue requests from correctional centres, and we have seen how having a restorative justice lens in certain instances can have a positive impact on victims. Bringing victims and perpetrators of GBV together however must be approached with caution and a deeper understanding of the unequal power relations that may exist between the victim and the perpetrator. NICRO will share a few case studies, creating an opportunity for the voices of victims, perpetrators and children affected by GBV to come through, as well as share challenges and lessons learnt from their diverse spectrum of work in the field of GBV.

Notes on PowerPoint Presentation – Venessa Padayachee

Slide 1

NICRO has worked with people in prison for more than a century and has worked with both victims and perpetrators. No one is unaffected by GBV. Speaking personally, she said that her first client was a perpetrator of GBV. NICRO mission statement is to value the dignity of every human being. This can be very hard when faced with the horror of some situations. In the 21 years she worked with NICRO she has seen people who have committed horrendous crimes being rehabilitated. Therefore, NICRO continues with its work with offenders and their victims.

Slide 2 Introduction

Many victims face complex issues which are complex besides just one incident and one factor (like HIV). They need many strategies and interventions. There is of course a large focus on women as victims and NICRO has used restorative justice (RJ) interventions.
Slide 3 HIV and GBV
Some studies have shown that HIV prevalence among men who rape is high.

Slide 4 Theories of causality
The danger is that the sector cannot take a one size fits all approach to factors relating to causality.

Slide 5 NICRO’s work in the GBV field
Restorative justice approaches can assist the victim to find their work? Victim empathy is the first aspect of such a system, cases where the traditional courts were not favoured by the women victims as they are frequently not represented.

Slide 6 Restorative justice (RJ)
In SA the offender initiates the restorative justice programme. They have found huge gaps in victim support. RJ always needs consent and PrEParedness of the victim. This is an essential part of the RJ process. It gives victims a chance to ask those questions they have never been able to ask previously. RJ can be alternative and complementary to the criminal justice system. Usually it is attached to a suspended sentence or protection order.

The more information they have about all the aspects of the crime, the victim and the perpetrator, the better.

Slide 7
RJ cannot be considered as enough but is part of a holistic strategy. Meeting with a victim before they meet the perpetrator prevents coercion which allows the victim control over the process. She then gave an example of a case where separation was negotiated by the RJ process which made the victim more empowered in the way the process unfolded.

Slide 8 Lessons learnt
Monthly they consider how they can look at these matters more holistically in a multidisciplinary manner.

Women have been found to be dissatisfied with the justice system’s response – women need a victim-centred process. The accountability issue is key – power is the dynamic in a GBV relationship. Requiring accountability on the part of the perpetrator opens the space and prevents isolation of the victim. The RJ agreement highlights both issues of safety and that the perpetrator is accountable.
**Slide 13 Some considerations**

Victims should have the choice – it should never be a forced situation or one where the victim is not freely participating. This must be emphasised. They need to be hopeful. There are changes that are taking place and we must celebrate and acknowledge them. They must focus on a sustained way in the whole of society in dealing with this scourge and RJ is just one of the parts of the whole.

The programme director encouraged all to tweet and announced that prizes have been donated for those who tweet the most during each day of the conference.

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**Questions arising out of the second session**

1. The research into SW did not cover partners – I would like clarity: in relation to GBV was there any link to that sort of issue of violence relating to failure to earn by the sex workers?

2. SW who are HIV positive – are there interventions that target the partners of such workers?

3. Pre-release of perpetrators is when we start looking for the victims. When will the focus be on the victims at the same stage – victims are left behind initially and are not being taken care of after the perpetrator is released.

4. With approaches to counselling how do they translate to working with children?

5. HIV and IPV the research shows no link; how many of those who have experienced IPV are living with HIV?

6. Over 400 sex workers have partners (according to Venice’s study) – do their partners know they are SW and do they know about the dangers to themselves and the SW herself in the participation in the industry?

7. Perpetrators usually go for RJ before parole – is it used to get early-release?

8. During the RJ process victims are protected but what measures are put in place for their safety if there is a relationship between the victim and perpetrator?

9. Involvement of men in GBV – some men are perpetrators and victims in the criminal justice system – to what extent is it effective to neglect the violence experienced in prisons, which reflects the patriarchal and toxic masculine environment outside? How effective is the system if it doesn’t address this? Or does it reinforce and reflect the environment?

10. Looking at PrEP for SW, how effective is it for them? They offer their services and receive PrEP – how do they deal with a client who refuses to use a condom?
**Answers**

**Venessa Padayachee**

**Abuse of RJ** – It is an issue when applying for parole. For the perpetrator there is a need to meet the victim and they need to understand the consequences, but they believe that the policy should be challenged and should not be linked to parole. Victims should know about RJ interventions at a far earlier stage. Victims support at courts should be available.

**Safety of women** – If there is RJ in prison and the offender comes out the women involved must be safe. This is where the agreement comes into play. One needs to work out accountability and consequences. Perpetrators must be helped to take accountability.

NICRO also deals with complex issues – men as victims is part of what they do and it does need more research. If society does not deal with it, it adds to the potential for violence within society.

**Venice Mbowane**

**Partners' GBV and stats:** 22.9% of SW experienced violence, but not because their partners knew they were selling sex.

**After the test do they also support the partner:** they run a programme for all victims including partners which includes ART and PrEP. If a partner wants to access the services they come in as a general client, especially if they notify us in advance. They refer them out and do follow ups.

**HIV prevalence:** 508 in the study, over 300 were HIV positive

**Knowledge and IPV:** The knowledge of partners selling sex has no influence on IPV. The dynamic of the community does not require SW to be revealing in dress. SW are not simply or easily identified and thus there are dwindling numbers of IPV impacted by this. They have reached these people during the study.

**Working with men:** There was a challenge in the Diepkloof Hostel where abuse of SW was rife. They consulted with the tavern owners in that space and involved them in the solution. They helped the SW to open cases and get treatment. They recently held a workshop to highlight these issues and encourage clients and pimps to come into the programme to begin to counteract this challenge.

**Services:** Some services are offered at the hospital.
Kempie van Rooyen

Children – treatment options are different, but the focus may also be slightly different. Often treatment has involved a lot of parent training (in a broad sense to include care workers, social workers, teachers) to help children adjust. The needs of children must be considered but a similar strategy can be used.

Sexual abuse of men in prison: Many perpetrators have been damaged or from systems that damaged them. They need to be thinking about a key intervention, which is how we raise our children. Thinking about the development of a culture of violent masculinity people can do a lot beforehand, before the violence occurs. Reparenting is basically what he was talking about here.

Second round of questions

1. A lot of evidence points to the fact that criminalisation of sex worker rather than the sex work is the driver for GBV. This is not necessarily so.

2. Human trafficking and sex workers – a lot of girls are taken to the areas where they end up in SW under the wrong impression. There is a link between rape and sex work. Perhaps there is a need for a study between trafficked people and sex work.

3. RJ does not work right now. How can RJ become effective? Anger management is also essential as a tool used to prove that they can be released. How can we look at a new review to look at so that it doesn’t affect the family and household?

4. View of GBV versus violence against women?

5. It would be great if everyone could have access to social work services, but we don’t have this luxury and if we look at the statistics, how does the proposal from Kempie work within this? Some people cannot get away from an abusive environment.

6. Has any research been done on secondary victimisation, this is commonly experienced in the LGBTI community?
Answers/closing remarks

**Venessa**

She was not sure if she understood the entire question about RJ but was thankful to have had the opportunity to listen to the other speakers and wanted to thank people for the opportunity to listen and engage. They never stop learning and we can work on a strategy together.

**Venice**

We still have a long way to go when dealing with SW criminalisation as the recipient should also be criminalised. They need to understand the key populations, and this is a challenge. Marginalised group who do not receive the services they need, are also subject to stigma. They are missing out on services to human beings based on this stigma. GBV and violence against women is the same, whoever the woman may be or the work that she does. It is violence and should be outlawed. Still a lot of work to be done and they must work together.

**Kempie**

*Services for women who are repeatedly raped* – one of the things that counselling does is also to help people to integrate into a just society. They can help people get used to living with violence – and obviously this raises ethical issues. PTS is often spoken of and stress is continuous. When they do counselling they cannot ignore the social justice aspects and must include this when they counsel.

*GBV and violence against women* – often differences are constructed on superficial levels. Humans are not different, and they have similar needs. The core of most people they are just people thus nomenclature is less important.

The programme director thanked all panel members and delegates and encouraged all to use the poster boards outside to record their thoughts and make suggestions. The director also encouraged using #enditnow when tweeting or communicating.

18:30 Cocktail & Entertainment

END OF DAY 1
Welcome and Recap of Day 1

Venessa Padayachee welcomed all to day 2 of the programme. There was a full programme, and all were encouraged to participate.

Nomfundo Majola did a brief recap of day 1 and welcomed all participants to the second day of the EndItNow conference.

The previous day they had an array of speakers and there was something for everyone to take home. Caroline Wills welcomed all, then Phumelele touched on the normalisation of GBV and the wonderful choir set the tone for the rest of the day. Sharon Kouta shared key interventions of the IPV project. Emma from FIXED spoke on strategies for breaking the cycle of violence. Shukumisa highlighted barriers to reporting and research into TCCs. Hasina spoke about She Conquers which focuses on young girls highlighting the levels of infection in the age group. Kempie van Rooyen touched on rape counselling and the importance of counselling for healing. Venice shared information on factors associated with IPV among sex workers, highlighting HIV levels and GBV within the industry. They saw a video from rape survivor Alison and heard a poem, reminding all about the brutality of violence experienced by women and that their work allows survivors to rise again. Venessa Padayachee highlighted RJ and how it can empower women who have been abused.

Venessa then took the delegates through the programme before calling the Tiger Boys to the stage to provide the entertainment which started the day.

9:30 – 10:00 Entertainment

Tiger Boys, Ekhupoleni Mental Health & Trauma Centre, sang a repertoire of songs which inspired and encouraged the delegates for the day to come, followed by a slam poetry/praise-singer’s performance praising the work of NACOSA, AFSA and the Global Fund and calling on all to #enditnow.

10:00 – 10:30 Key Note Address
End it now! Together in response to GBV and HIV

Rose and Joe are married and have two children. Joe is physically abusive; he often kicks and punches Rose. She miscarriages their third child and is hospitalised. Joe also abuses the children - he throws their 2-year old onto the floor and their 7-year old against the wall. Joe has multiple affairs and Rose eventually tests positive for HIV. Joe won’t allow Rose to work but he also doesn’t provide sufficient money for the family to eat or survive. One day he beats Rose when he finds out that she asked a friend for food, so she could take her medication. On another occasion he stabs her, but the case is thrown out of court because the medico-legal document used to document injuries sustained by victims of physical assault and rape was not properly completed. Rose applies for a protection order; however, the police instruct her to accompany them to serve the order on Joe. She refuses as she’s afraid. She seeks refuge with family, but he finds her and beats her in front of them. She lays charges with the police, but when he is not arrested, she tries to kill herself by drinking rat poison. She is hospitalized. She goes back home. He beats her again; he beats her so badly that her cries alert their neighbour who calls the police. The police ask Rose what she did to “upset” Joe. They give him a warning and leave. The beating continues. The neighbour calls the police again. Now this story could have ended with Rose dying that day and possibly her children ending up in the foster care system, but fortunately for Rose, her neighbour knew that the police have a duty to take cases of domestic violence seriously. She also knew that, according to the Domestic Violence Act, the police must help abused women find shelter. Rose and her two children are taken to a shelter for abused women and their children. The shelter provides the family with clothes, toiletries and three meals a day. The shelter also provides in-depth therapeutic support to the family and help Rose access medical care. They help her to re-apply for a protection order and provide other legal support. The shelter places Rose’s daughter in school, pay for her school uniform and daily travel to and from school. Rose’s son attends the creche at the shelter. As Joe had at some point torn up Rose’s Identity Document and the children’s birth certificates, the shelter pays for these documents to be replaced. They provide Rose with skills development training and support her to complete her matric. They look after Rose’s children while Rose attends evening classes. The shelter extends the family’s stay by 6 months to allow Rose to focus on her studies and in the meantime, help her find a job. Once Rose finds employment and has been able to generate some savings, she and her children move out of the shelter into their own rented accommodation. The story in this version ends on a happy note - through the support and extensive range of services that the shelter provided, Rose’s children leave the shelter with their mother, healthy and happy, no longer afraid. Rose too is much healthier and happier than she has been for a long while. She has been able to finalise her studies, to find employment and through that, access affordable housing.

This is not always the case.
INTRODUCTION

Rose, Joe and their two children are fictional characters, the story however is not: it has been woven together to tell not just one but multiple stories of women’s actual experiences of domestic violence at the hands of their intimate partners which the researchers heard while undertaking research on shelters for abused women and their children.

The purpose of the talk today is to share some of the preliminary findings of research undertaken in shelters by the HBF and NSM’s EU funded project: ‘Enhancing State responsiveness to gender-based violence: paying the true costs’

The project aims to:

- Support State accountability for adequate and effective provision of domestic violence survivor support programmes, specifically those associated with the provision of shelter for abused women.
- Strengthen and build capacity of shelters
- Strengthen referrals to shelters
- Raise public awareness of domestic violence and the importance of shelters as a key response to providing reprieve for victims of GBV

The focus will be on violence against women, particularly IPV, with the recognition however that violence knows no gender, race, culture class or sexual orientation.

The UN Committee on the Elimination of all forms of Violence against Women (CEDAW), has described violence against women in South Africa as:

‘...socially normalised, legitimised and accompanied by a culture of silence and impunity.’

- South Africa is known to have one of the highest rates of femicide in the world. Estimates suggests that 3 women die in SA each day at the hands of an intimate partner or someone they love or at some point had loved.
- Research also indicates that following HIV, IPV is the second highest cause of disease burden in the primary healthcare sector.

VAW holds significant psychological, social and financial costs for those directly affected by the abuse.

It is also known that it holds significant economic costs to the State.

But there is a far bigger cost involved in the long-term if we do not adequately invest in services, such as those that shelters provide.

Not adequately investing in services has far reaching, devastating consequences not only to the victim and their families but to all of society and those of future generations. Shelters are a “critical point of crisis intervention” in this regard; an
intervention that is both responsive to the impact of violence on victims/survivors and their children and families, but that which also is preventative.

The State’s response to shelters?

- Provision of shelter is state legislated mandate e.g. the right to housing and protection (to name but a few) is asserted in the Constitution, the OVA, and various international treaties that the country is party to.

- The DVA places an obligation on members of the police to provide specified services to victims of domestic violence including as mentioned earlier, referral and transfer of women to shelters. The Act does not, however, specify who is responsible for the provision and funding of those shelters.

- At present, although there is some work on this now, we do not have a legislative framework that guides and regulates the funding of shelters, but we do have policies and strategic plans that assert this responsibility onto the DSD. The department has a responsibility to ‘facilitate and fast track the provision of shelters’, and to fund them.

- Provision of services in relation to shelters, according to the minimum standards on shelters for abused women and minimum norms for victims of crime and violence, includes that shelters must:
  - Meet the basic needs of women and their children
  - Provide support, counselling and skills development
  - Ensure the safety and security of shelter residents (amongst other criteria)
  - Must be run by responsible management.

IS GOVERNMENT ENABLING SHELTERS TO DO SO?

Essentially, if the DSD is not able to provide the services themselves, they need to ensure that others are able to do so on their behalf. This means also all those who need them and that the services must be of an adequate quality. This in turn means that service providers must have adequate resources. However, according to government’s policy on financial awards to service providers regulating funding to NPOs, NPOs are expected to meet the deficit in their finances through securing funds from other donors. This is very different from instances, such as construction of roads or provision of other services, where government pays service providers the full cost, plus profit.

What the research says

In two provinces, Mpumalanga and KwaZulu-Natal, the research included case file reviews of women who had accessed shelters in 2015/16; 48% (78) were at the shelter because of IPV, along with 86 of their children.
1. WOMEN & CHILDREN HAD SIGNIFICANT PRACTICAL NEEDS AND LIMITED/NO MEANS TO COVER THEM.

- VAW cuts across all ages, at shelters this ranged from 18 to 71. However, what they did see is that most women were quite young - aged less than 36 years.
- They had limited education; on average 63% of women had less than a matric qualification; 11% had only primary school education or no formal schooling at all.
- Only 26% of women were in full time employment; only 15% of women were in receipt of a child support grant; very few women received maintenance from a partner.
- The majority of women therefore had limited if any means to cover their material and practical needs. This means that shelters had to devote significant resources to meet these needs.

2. WOMEN & CHILDREN HAD SIGNIFICANT HEALTH & PSYCHOLOGICAL NEEDS

- Women had multiple and often concurrent medical conditions
- Most of these problems were related to the physical and psychological abuse that they had experienced. This included:
  - Physical injuries (burns, stabbings, broken limbs, partial blindness, being shot amongst other acts of gruesome violence)
  - Depression, PTSD and other psychiatric conditions, and suicidal ideations (like Rose)
  - A few were also HIV+
- Children also presented with physical injuries, suicidal ideations, PTSD and other health problems.

3. WOMEN’S LEGAL NEEDS WERE EXTENSIVE

Most women entering the shelter required other legal services including:

- Following up on DV cases
- Instituting divorce and custody proceedings
- Court preparation
- Applications (or renewals) for IDs and child certificates
- Application for state grants, state-assisted housing and so on
4. **THE PROVISION OF SHELTER CAN BE PREVENTATIVE**

On average, only about 25% of women returned to their partners, and returning meant failure in that it meant that they were not made more empowered and confident in the shelters. This depended on several factors:

- The extent to which shelters have been able to adequately provide therapeutic support to survivors. Their length of stay at the shelter
- If skills-training or other forms of assistance to find employment are on offer and are of decent quality.
- If woman have other forms of support such as families and/or some form of access to housing.

5. **GOVERNMENT FUNDING TO SHELTERS IS INADEQUATE**

With the myriad of practical, psychosocial support and care that women need entering shelters, it takes resource capacity and expertise to deliver that care and support. If shelters do not have this, this has implications for abused women’s safety and security as well as their prospects, and that of their children.

Our research also included analysis of State budgets and annual reports; DSD funding agreements and the audited financial statements of 17 shelters in 4 provinces.

Despite shelters being a national priority, they do not appear to be a funded priority.

- On average national DSD contributes about 10% of its budget to social welfare programmes. From there, provincial department assign between 1-2% of their budgets to VEP which is where shelter funding comes from. From there about 1/3 to 1/4 of VEP funding is diverted to shelters. VEP is generally the least funded social welfare programme. Of the R14m allocated to VEP, R7m is allocated to shelter funding.

PROVINCIAL FUNDING ALLOCATIONS VARY

The DSD funding ‘model’ varies from province to province and even within the provinces. Overall, the DSD seems to adopt the approach of funding shelters at a rate of per ‘bed’, per day or per woman per day with some subsidies towards shelter staff. This is true of every provincial DSD except for Mpumalanga, which provides a lump sum of funding dispersed in quarterly tranches that shelters must claim.

It does not specify unit rate contributions, nor does it refer to salary subsidies in respect of social workers.

In some instances, the DSD contributes funding towards community awareness campaigns, care-packs for residents, and some administrative expenses. Some provinces also contribute to security measures, but this funding is limited at R1000 per month.
In 2015/16, this unit rate contribution per woman, per bed, per day, varied from R48.92 in Gauteng to R63 in KZN. This rate is intended to cover residents’ food, accommodation, and other day-to-day expenses. If we were solely to divide that R49, (for example, meals) this means that 3 meals a day cost R16 each.

There has since been some unit rate increase: in Western Cape and Gauteng, this rate increased by R1 and in KZN by R4 and I think we can all agree that this is very little considering the many needs of women and children.

Funding is also restricted to length of stay at the shelter. For example, shelters offer stays of 3-6 months, but 3 months is the general trend as shelters are set targets to reach. In one province the DSD will not fund a unit rate for a woman if she stays 4 months or longer. In other provinces, the DSD only provides this unit rate contribution if there is a woman in a shelter. However, one needs to consider that whether the shelter is filled, operational costs such as rent or other amenity costs are still incurred.

**DSD FUNDING INCLUDES SUBSIDIES TOWARDS STAFF SALARIES**

The research found that this also differed from province to province and again even from shelter to shelter.

- In KZN for example, the DSD subsidised the salaries of social workers (SW) at a rate of slightly over R11 000 whereas if one looks at an entry level Government SW salary, this ranges from R17 000 to R23 000 a month. Obviously, this is a wide disparity.

- A centre manager at R5 000, to house mothers at a rate of R2 500 per month each, a handyman at a cost of R2 000 per month and a cleaner at R1 600

- In the Western Cape SW salaries where better than KZN at an average of R14 000 but the DSD in that province does not subsidise the salaries of centre managers while house mothers earned R2 116. Each shelter has 2 house mothers but DSD funding does however include a subsidy for a relief house mother at a rate of R2 116 a year – let’s put it this way, at the rate of R176 a month.

- At a shelter in Mpumalanga the SW who also served the role of centre manager, earned R2 800 a month, while the rest of the staff (i.e. care workers and house mothers) earned R1 800 each or R59 a day. This shelter is in a rural area with limited access to other funding or donation sources. This shelter was not able to find money to further supplement the salaries of staff so these figures are what staff took home.

- Although the research did not focus on Free State, the situation is even more dire in this province; for example, in one shelter which has an occupancy of 16 beds, social workers are paid R3 000 on a part time basis, while full time staff members such as the shelter manager, earn R1 250 per month and their house mother a meagre R600. This is not even a volunteer stipend.
What this highlights, again, is that care work is undervalued and underfunded.

If one considers for example that Govt’s sectoral determination for domestic workers at that time was R2 230.70, care workers/house mothers were not even earning the Government minimum. And these are critical staff who do more than just housework. Considering SA’s minimum wage has just increased to R3 500, one wonders to what extent this will translate to increases in funding to shelters for these key personnel. In my opinion, it is highly doubtful that this will influence increases in the funding for the care work sector but at the very least it could be a platform for advocating for increased resourcing.

When looking at the overall funding contribution of DSD to the operational costs of the shelter during 2015/16, DSD funding contributed 37% to 90% of the shelter’s annual operating expenses. In some instances, DSD funding covered the full budget but this was often because shelters were unable to find other sources of funding. When there is limited funding this means that shelters are not able to provide the range of services required and cannot meet DSD’s minimum standards.

**ADDITIONAL CHALLENGES:**

- They ranged from funding-disbursement delays, which in some cases resulted in shelters having to use savings, if they had such luxury or if they didn’t, having to forgo staff salaries and borrowing money to buy food for shelter residents. Delays vary from 1 to 3 months.
- This has significant ramifications not only for an organisation’s operational stability and its services but also has serious ramifications, for staff and their families.
- Hence it is not surprising that shelters experience significant difficulties in retaining qualified staff, further undermining the rights of GBV victims to the appropriate care and support.
- Their research also indicates that government-run shelters are better resourced and do not face the same constraints that those run by non-governmental organisations do.

Despite these constraints, most shelters try their best to provide a range of psychosocial, practical and legal support services.

Most can provide some form of skill development in the form of beading, knitting, gardening, computer skills training and so on.

Again, depending on funding and considering that skills development is a minimum standard but that Government does not fund it, this is yet another problem.

Service provision to children is also a challenge to most shelters. While they provide many support services to ensure that children are looked after during the day or can access schooling, most shelters did not have formal programmes to address the psychosocial challenges of the children in their care.
While some of the shelters provided some group support/informal play therapy, inadequate funding and capacity prevented shelters from establishing these programmes or hiring qualified personnel to provide these services.

Children requiring more in-depth therapy were often referred to other organisations such as Childline but with waiting lists of 6 weeks, the child’s access to this much needed service is greatly impeded, particularly when one considers the short duration of such shelter stays.

CONCLUSION

In conclusion, the research indicates that state funding to shelters is insufficient and inconsistent, which means that DSD is not sufficiently supporting shelters in meeting the minimum Norms and Standards on shelters for abused women.

Shelters are constrained by limited staff capacity; SW are overburdened with case-loads and find meeting targets and reporting further impedes their capacity and ability to provide holistic, effective and sustainable support services to their residents. The short duration of stays at shelters may impede women’s ability to heal and fully escape the clutches of abuse and while some shelters are able to offer skills development, the range and quality of skills development training is not sufficient to address women’s economic vulnerability.

While the DSD has overall responsibility for the provision of sheltering services for abused women, there is certainly a need to look at ways to better synergise the roles and resourcing contributions of different government role-players.

A multi-departmental response would ultimately ensure that a more comprehensive, holistic, sustainable and effective strategy, backed up by the requisite budgets was developed, to address some of the true costs of GBV in our society.

Thank you.

Venessa thanked Claudia for the presentation and for the passion with which she spoke. Funding is a severe challenge but there is hope in the idea of multi-departmental support. There is also hope for the women who come out of the shelters. Working in the field is traumatic for all and she thanks and supports all those who work with abused people. This contributes to a healthier nation and is critical work.

10:30 – 11:00 Plenary
A Multi-Faith Response to Addressing the Faith Dimensions and Root Cause of Violence Against Women

Megan Robinson, South African Faith and Family Institute (SAFFI)

ABSTRACT NOT AVAILABLE

She began by saying that she acknowledges the amazing work done by all in the room and expressed the hope that they can find ways to work together so that the work can feed into each parties’ work. SAFII, as with all organisations, come from a focus and she acknowledged the different work done by each representative organisation.

Notes on PowerPoint Presentation – Megan Robinson

Slide 1
By faith they do not mean organised religion. Family is often the first point at which people experience faith.

Slide 2
Various root causes are described which influence how women experience violence. SAFII acknowledges that religious leaders are often in these systems of oppression.

Slide 3
There is an intersection between faith and women experiencing violence. For example, divorce – if that goes against one’s belief it can be more difficult to navigate even where there is IPV.

Often faith counsellors are not trained in GBV while secular counsellors are trained to ignore faith. If they can be brought together that can benefit women.

Where faith is used to justify violence, faith can be a mechanism as well as one of the coping strategies of GBV.
We want to be a resource to religious leaders and faith communities to assist them to navigate these challenging waters.

They work with the concept of Ubuntu – a person is a person because of other people and this they include into their workshops.

**Slide 5**

**Strategies**

Because the field is nuanced and complicated they use various strategies. They also train within family and premarital communities; this is to support the prevention of violence as if there are clear understandings at the start of the relationship, violence can be avoided. Our work also includes workshops on these issues.

- Sacred conversations – these are multi-faith and sometimes faiths can come together and inter and intra faith approaches can be developed.
- Legal and social work.
- Theological counsel: senior leaders to help with the meanings of sacred texts.
- Research.
- Strategic partnerships have included UWC.

**Slide 6**

**Overview**

They have a longer journey to travel with religious leaders:

Phase 1 is a one-day workshop on how faith and violence intersect.

Phase 2 is a longer workshop as the attendees are familiarised with social work and can connect with other actors in their area so that there can be a holistic response.

Phase 3 consists of a 10-week resource series, which at this stage is only available within the Christian community. They can engage with their common ties around these issues and their ways of developing strategies.

Phase 4 is the development of forums and support systems for religious leaders. They are under a lot of pressure and sometimes need extra support to do this valuable work.
Slide 6

Lessons

Hopefully this engages the conversation. It has been a great learning experience. Perceptions can cause trouble and challenges on how to deal with tensions within the sector - e.g. faith does not always deal with GBV and visa versa.

Facilitators and work must be part of what they do so that they can all communicate and work with one another to combat this scourge.

Slide 7

Facilitate networks of support

Providing support really helps with the overwhelming nature of the work and encourages people to remain motivated. Support motivates the communities as well, helping them to participate in finding the solutions. People’s own experience of violence can encourage them to change especially if filtered through a religious leader’s interventions and encouragement. Therefore, the work with religious leaders is critical.

Slide 8

Culture and race

How do they start deconstructing the understanding of gender? If they do, then men start to be brought into the conversation needed to combat GBV.

Slide 9

Questions arising from the work:

1. E.g. disabilities – how do they create level playing fields?
2. Don’t just avoid the victims who may need your support to escape their situation.
3. Respect – a tenet of our work is that they are not critical of culture/cultural practices.
4. How to disrupt rigid notions of gender

They do not have all or even some of the answers, but these are some of the questions. Venessa thanked Megan for reminding all about the link between religions and GBV how one needs to challenge patriarchy as a precursor to eradicating GBV.
Understanding Victimization and Poly-victimisation Amongst Female Sex Workers in South Africa

Maya Jaffa, Perinatal HIV Research Unit

BACKGROUND
Globally, evidence highlights the deleterious living and working conditions sex workers face. South Africa has a dense HIV epidemic, with Soweto SWs having an HIV prevalence of 53.1%. Yet little to no evidence is available describing their lifetime exposure to violence, which has been shown to increase vulnerability to HIV. This study aims to describe the prevalence of violence by perpetrator and violence type, as well as explore poly-victimization, amongst FSW from Soweto.

METHODOLOGY
Our study took place in Soweto, a township on the outskirts of Johannesburg, South Africa. The location is predominantly urban and peri-urban, resourced-limited with minimal educational and employment opportunities. A respondent driven sampling methodology was used to collect cross sectional survey and HIV data from 506 female sex workers across the township.

FINDINGS
Almost one quarter of FSWs had experienced sexual violence and 48.6% experienced physical violence by an intimate partner in the preceding 12 months. Overall, 68% reported experiencing physical violence and 30.4% sexual violence in the past 12 months by either an intimate partner, client or the police. Lifetime exposure to violence by any one of these perpetrators was 82.3%. One quarter had experienced sexual assault in childhood, and lifetime exposure to sexual assault was 54.1%. Data is currently undergoing multivariate analysis.
**IMPLICATIONS**

Our findings have clear implications for the urgent need to intervene to prevent client or intimate partner violence through developing strong multilevel interventions. The study will impact policy in South Africa, relating to the protection of women’s rights, and human rights violations. Findings will also impact upon various strategic plans geared to supporting sex worker HIV prevention and violence reduction.

Maya commented that she was a last-minute presenter hence the slightly rushed nature of the talk. This research which she was reporting on is also part of the approach which Venice spoke about yesterday. (NOTE: most of the conversation was on the slides) The research and abstract are in the programme under the name of Jenny Coetzee.

**Notes on PowerPoint Presentation – Maya Jaffa**

**Slide 1**

**Background**

Sex workers are uniquely vulnerable, and it is essential to think about them when confronting GBV. They are facing concurrent epidemics of HIV coupled with mental health and violence. This topic is an intersection.

SW are criminalised which causes stigma, lack of protection, and unsafe working places leading to elevated levels of violence.

Looking at HIV – where women are unprotected they have found that men are less likely to use condoms, increasing the chances of infection.

Mental health caused by violence, means that adherence becomes a problem as well.

**Slide 2**

The study ran from 2015/2016

**Methodology**

This is a repeat of study findings from yesterday.

She highlighted the vulnerability of women who had not finished their schooling. They are less able to free themselves and more likely to become involved in SW.

Almost all women had an intimate partner and they need to think about the IPV experienced. Most women did not know or consider that they were sex workers. The researchers do not clearly understand this link as the data is unclear and there needs to be much more research to clarify the issue.

Childhood trauma was a very significant factor in women entering SW.
They had expected police violence to be higher than it was, but they think this is because there is different policing of sex work in different areas. In the inner city the industry (and the policing) is very formalised which leads to greater police harassment while in Soweto, where the work is more informal and ad hoc the policing is more a case of neglect with consequently much fewer reported incidents of police harassment.

Maya then commented generally on the slides and the study:

The study highlights how high these categories of different SW are. Violence is experienced by almost all women at some stage in their lives.

- Sexual Assault – gang and stigma related rape are there but the results are far lower than may have been, though they can underemphasise the levels of IPV and client related rape as expected respondents are frequently reticent about it.
- Women who experience IPV are more likely to experience other violence.
- Poly-victimisation is frequent and external discrimination associated with poly-victimisation.
- Those who had not experienced external discrimination had a lower incidence of violence.
- The researchers think this depends on whether people know that you are a sex worker or not (which makes you more vulnerable.)
- What do they (Perinatal Research Unit) do?
- They run a walk-in health clinic in Soweto offering health services for SW. They also offer outreach services.
- Firstly, what is it to identify as a SW? This may also include all women who may not self-identify as SW.

Services include:

1. Trauma – 3 trained counsellors who are former SW trained in trauma counselling
2. 8 peer educators trained in human rights violations – they do outreach and assist with the reporting of violence. What they need to highlight is that they do not have a specific intervention that addresses violence. Can get funding for HIV, PrEP but less so for violence.
3. They often think of SWs simply as such, not as mothers and partners. Family interventions are key in addressing this lacuna. They are often guilty of simplifying the clients lives. They need to identify and talk about family and home-based work as well.

Venessa thanked Maya for sharing the information, including the alarming statistics which show how much they must do. Venessa said that she appreciated that what Maya did was to reflect on our practice which meant that everyone has learnt something from her talk.
10 minutes were available for questions, limited to one question per delegate.

Questions

1. SAFFI – do you focus only on Christianity, and who are the council members?
2. In SA there is so much news about rapes by pastors, what are your interventions?
3. What are the challenges with working with the pastors – they are often obstructionist and they are unwilling to discuss anything other than abstinence
4. Shelters – the research findings were interesting but there is a loophole in the findings – there are very limited solutions which are only asking for additional resources. Some solutions are not a real solution. Often this can be a vicious circle as it does not allow for growth. People need more than gardens to make a living.
5. SAFFI – how does it monitor the success of the workshops and other interventions and please discuss the challenges in bringing the people together.
6. SAFFI - Are there programmes for the LGBTI communities?
7. Maya – what was the response to your outreach programmes?
8. Maya – I listened to your research and am concerned that they focus on female sex workers and not on their children? Has any study done this and what other pathways were encountered to show us what treatment should they follow?
9. SAFFI – LGBTI is difficult for Imams; how does it allow for reconciling your sexuality?
10. Class action for minimum wage for those working in shelters – are they going to do this?
11. Comment – reiterating what CM said – Government does not value the work of care workers. DGS do not value or understand the work they do but they need more of such people. The shelter model works better with 3 house mothers but they (DSD) do not accept this. Currently they only have 2 house mothers. If one is off, the women are left alone in the evening which causes problems. They still need support and help during the night. This is frustrating, and they need Government to hear what they are saying

Answers

Claudia Lopes

In the presentation it is said 3 key elements make up the sector. Skills development is lacking. They understand that gardening is not enough. There is a need for a concerted effort to develop better programmes. Some shelters do focus on this, but
the challenge is to find funding and staff to provide this type of skills development. My focus was specifically on the extent that Government can intervene. I agree about the gap regarding child care.

We have been doing a costing workshop over the past 2 days which shows that 3 house mothers are essential. They can engage later during the conference on a one-on-one basis.

She said she was very keen to get involved with a class action, and they agreed to talk later.

### Megan Robinson

We work with a broad range of faiths in developing different responses depending on the faith, and using different strategies. At the moment it is generally just to Christianity and they try to infuse it into others. Most workshops are attended by Christians probably because of where they are situated.

Council is made up of mostly senior leaders of different faiths in SA; they are trying to be inclusive. The council members already represent their faith on other forums which they find essential to get a sound theological interpretation of the different texts which then guide how they work.

Pastors and rape – our work includes this and is often brought up by religious leaders. They encourage them to challenge each other. There are challenges working with pastors and they need to create credibility and trust. Our programmes are designed to assist with this.

It is not always easy and needs to be negotiated carefully and respectfully.

M&E is done; they also do follow up interviews; engaging in continuous conversation to see where they fit into the social environment. It is always a negotiation, and a continuation of the journey.

Reconciling faith and sexuality. SAFFI not interested in saying what families should look like but that all families should be protected and valued. This is where Ubuntu helps – people are people and they use this to address sexuality. They try to facilitate conversation regardless of the person’s view of sexuality.

### Maya Jafee

Response to outreach – she echoed that relationship building is key. This means meeting with police, brothel owners and other role-players before they start to provide services. They explain that this is to their benefit – accepting that some may also be perpetrators – and can be a productive exercise. This way they get support from them.

Safety must be paramount and people who work with us must be safe.

SWEAT: 2 issues – children of SW appear to have high exposure to violence and typically the children are in the same space as where the SW occurs. There is no
research on the health outcomes of these children, globally. They are trying to get some funding for this. There are a multitude of challenges, including issues of confidentiality and child-safety.

Also, regarding adolescents who are themselves SW – ethically this very challenging and they cannot do this research as they are primarily the ones who need protecting. This means there is very little data and they need to find ways to establish research protocols and systems.

Treatment approaches – they need to look at both individual and at a systemic level. It is a multi-pronged approach. They really need to look at systemic approach particularly sensitisation training with the police.

Venessa thanked all the presenters and delegated for the questions and the responses before announcing a break for tea for 20 minutes.
11:30 – 12:00 Panel: Community Level Responses & Interventions

Sharon Kouta and Venessa Padayachee welcomed the delegates back and asked the panellists to come forward to the stage.

Gender-based Violence and HIV/AIDS amongst children and youth on the Cape Flats

Valdi van Reenen Le Roux, Trauma Centre for Survivors of Violence and Torture

BACKGROUND

Gender-based violence is a global public health scourge affecting women more than men. The rate of gender-based violence in South Africa is exceptionally high with the homicide rate of women by intimate partners been six times the global average (Seedat et al., 2009). Women and children living on the Cape Flats experience multiple forms of violence which impact on their psychosocial and economic stability.

This study is a participatory action research which relied upon a mixed method research methodology to investigate the extent to which violence, more specifically gender-based violence affected children and young adults currently at institutions of learning. Trauma-focused screenings and interviews were undertaken at six schools and five TVET colleges in the Western Cape.

The findings reveal that intimate partner violence is one of the highest forms of violence experienced by school-going children and TVET adult learners. Suicidal thoughts and tendencies rank the second highest. Learners were keen to know their HIV status, particularly those who had experienced intimate partner violence, sexual violence as well as those who were sexually active. Men and boys indicated their vulnerabilities as victims of gender-based violence as well.
A challenge at the schools was meeting the needs of the learners for HIV testing services (HTS) versus the reluctance of the school authorities to provide permission for testing. Factors that influenced the refusal on the part of school management to provide HTS ranged from policy ambiguity, ignorance about policies relating to HTS at schools and fear of parental reprisal.

Preventative programmes focusing on gender-based violence are required for learning institutions. In addition, there is a need to align the legislative framework regarding the rights of children to HTS in schools.

This research is a work in progress and due to be completed within 2-3 years, which is when the NACOSA grant comes to an end. However, emerging trends and learnings are becoming established.

**SCHOOLS AND TVET COLLEGES**

Research was conducted in seven schools in communities with an elevated level of violence, particularly gang violence. Only one primary school was part of the study, because of age of consent. From these schools, where screening and services were provided, only five schools were analysed. The research was also conducted in 20 TVET colleges.

**METHODOLOGY**

They realised that there is limited understanding of IPV and domestic violence (DV) and that because of the stigma there was a reluctance to come for screening, especially in the class environment. As a result, they changed their screening to focus on trauma. The tool is based on 28 questions. They included questions about anger and concentration.

They also found that this approach gave them the necessary buy-in from school management, as they are very reluctant. This is particularly because of HTS services it appears.

They realised that they needed to provide an information session first, taking the children through what IPV and emotional abuse is before they could screen them.

They screened them individually and in some contexts, as a group. At TVET colleges, they provided solely individual screening. Here more women were open to screening while at schools both male and female were willing.

They found that learners, once screened, were offered and amenable to HTS services. This included pre-and post-counselling and a bit of sex education. They found that there was quite a bit of ignorance as Life Orientation classes seem not to be providing sex education. Once they had the data from each school, they presented the report to school management team with an action plan to initiate.

They worked with 1,989 learners and of the 8 schools provided HTS to 7 schools.
Often there was a debate about legalities and they were frequently encouraging principals to accept that GBV also, of necessity, will include HTS.

There was concern expressed about the reaction of parents. At one school, parents apparently know the status of their children, but the children do not, and this school was very reluctant to allow them to provide the HTS, despite being happy to allow GBV.

They only tested IPV violence survivors and then discovered many non-IPV survivors wanted HTS testing as well, which was problematic.

**See table of results**

IPV was the highest form of violence experienced by learners they spoke to although DV also featured among the results. It was not just a female issue and affected boys as well as girls.

At TVET colleges they worked with 20 colleges. They found that other NGOs, offering incentives, ‘grabbed’ the client for HTS. The challenge was that this HTS excluded GBV screening which means the testing is incomplete.

At schools, sexual violence was not a feature which was strange. This was because sexual violence is normalised through people trafficking and drug addiction. There are houses into which children are lured and then become prey to drug addiction, sex trafficking, or both. Often learners argue that they had consented to the sexual abuse, and they needed to discuss issues of grooming and human trafficking.

Suicide was also a category to mention. Learners often said they didn’t believe they wouldn’t live beyond 24.

Once of the challenges is the attitudes of teachers, who are ignorant about legislation and policy, are themselves traumatised and so the environment is not conducive, and education is seen through the narrow lens of imparting content alone. At schools with a high rate of teenage pregnancy they were more willing to allow HTS and GBV screening.
The prevention of violence against women and girls at community level

Kempie van Rooyen, Berenice Jacobs-Malgas, Jane Nglunga, Psychological Society of South Africa, Trauma and Violence Division

BACKGROUND

Violence against women and girls (VAWG) is a complex phenomenon. Some of the underlying risk factors and driving forces behind VAWG are well recognised, but the pathways to perpetration (and the prevention thereof) are not always well understood. While it seems clear to most that societal forces and especially constructions of power related to hegemonic masculinity drive VAWG these kinds of constructs are difficult to operationalise and measure. Despite these methodological difficulties there is growing evidence of what prevents VAWG and what does not. Although strong arguments are often made for changes in legislation or strengthening the application of existing policy to combat gender norms that marginalise women and girls, many strategies focus on the implementation of interventions that target individuals, small groups, or more broadly defined communities. There is limited rigorous evidence from low and middle-income countries (LMICs) because of methodological issues such as the privileging of attitudinal measures over actual behaviour change measures and small sample sizes. There also seems to be greater focus on somewhat reductionist methodologies to the detriment of complex and multi-component interventions to transform masculinities or change social norms.

However, it is at community or population level that efficacy for a VAWG prevention programme would need to be demonstrated, especially in LMICs where VAWG is pervasive rather than limited to specified risk groups as is sometimes the case in high income countries (HICs). The presentation focuses on the lessons learnt from a combined intervention and evaluation programme that targeted change at a community level (using schools as nodes of change) that reached approximately 3 000 community members. The design and rationale of the programme is contextualised against the international best practice research base, a theory of change and the South African VAWG reality. Quantitative and qualitative results
are presented with due cognisance of the limitations of the study. The quantitative results corroborate findings that attitudinal change is possible in the short term with brief interventions and large groups of individuals. Qualitative results indicate that the successful implementation of such programmes can be improved by expanding the role-players that are involved to law-enforcement agencies and key geographical locations such as taxi-ranks.

It was also clear from the intervention that there were some challenges in keeping key role-players involved and that this involvement had to do with logistical and perceptual difficulties. The presentation concludes with practical recommendations regarding the implementation of VAWG prevention programmes (including scalability) and their evaluation in the South African context. These include that prevention programmes should target communities rather than small groups over many years to create lasting change, and that intervention programmes should be brief, but include mechanisms that will keep the impetus of initial change going. Finally, the necessity and dual direction mechanisms to keep key role-players involved are discussed.

This brief discussion is what was planned for an hour and a half compressed into 5 minutes.

Partnerships are essential to this kind of work. The basis was schools and adolescents and involved schools and parents as well. GBV is a community based thing; it’s about conversations and influential members of communities.

It is said people don’t change because they are told to do so but because of specific processes and their readiness to do so.

The study involved high school learners. They were training for champions and change agents. They also held parenting training and focus groups. The work continued after the end of the study.
FINDINGS – HOW READY ARE PEOPLE TO CHANGE?

71% of learners tested were moved along the continuum of change. Similarly, with rape.

The intervention was brief, only 1-3 hours and changes were visible, particularly where the attitude was already positive within the school. They felt interventions were effective in what they were designed to do.

Long-term they could not evaluate the results because the schools were not willing to give them more time.

QUALITATIVE FINDINGS

Major changes were in rape myths (for example, women are to blame for rape). Here there was a significant and rapid change over a short and simple intervention, but they were afraid to speak in schools, despite schools being safe spaces.

Learners and parents were responsive to the interventions and the training.

The relationship of the rape crisis centre with the community was a contributor to the success of the project.

WHAT DIDN’T WORK

There were schools who were not willing to give them a lot of time.

Parents and schools’ miscommunication about the interventions and the need for them.

They will approach it differently next by approaching schools through the provincial education departments.

GENERAL

Long-term, the programme will be useful.

They evaluated attitudes, but they don’t know if they translated to actions.

Targets – feedback received indicated additional role-players who could be brought into the process. These include DOE, SAPS, DSD on a local level.
Civic Aptitude Resulting in Growth
Charlene Flavell & Aidan Connolly, The Relevance Network

BACKGROUND
Donor strategies have shifted away from long-term support and partnership models towards investment in organisations that demonstrate self-sustaining trajectories. This shift is – at least in part - responsive to a marked decline in foreign social development investment policies. Civil society organisations that address HIV with a focus on gender-based violence in the lowest-resourced settings are struggling to negotiate the implications of this socio-political transformation.

OBJECTIVE
To mitigate risk for programmatic collapse and loss of essential services for the most marginalised populations, we developed a web-based assessment tool (CARiNG – Civic Aptitude Resulting in Growth) to determine individual CSO strengths across core variables: governance, finance management, advocacy, social marketing, partnership, internal capacity building, and monitoring and evaluation. The rationale derives from two hypotheses: 1) measuring sector strengths within and across GBV CSOs can inform the need for targeted trainings; and 2) identifying particularly high-functioning CSOs could present opportunities for GBV network mentoring initiatives as a means of promoting core functionality in the absence of external support.

METHODOLOGY
Existing assessment measures for non-profit sector performance from several practice areas (e.g. HIV) were interrogated. Of these, evidence-based tools including the NGO Scorecard, NACOSA, and FANIKISHA were compared to determine donor-identified management priorities and analysis methods. Interviews with sector stakeholders and policymakers were undertaken to understand GBV-centric challenges. The multivariate data points were evaluated and synthesized, resulting in a comprehensive GBV-focused assessment module,
constructed on a platform for ease of web-based access, and designed for paper-based dissemination as a stopgap measure. Five geographically distant GBV CSOs across South Africa were enrolled for pilot research to measure potential effectiveness and user uptake. Subsequently, 19 additional CSOs were invited to participate in the assessment, yielding comprehensive data for 24 GBV CSOs.

RESULTS

All but one CSO successfully completed the modules with little or limited guidance. The algorithms employed to “dashboard” results allowed for accessible interrogation of results at multiple levels: national, disaggregated by question, governance area, CSO, beneficiary demographic, and province. Outputs can be visualised according to a broad range of customizable queries (e.g. line, quadrant, and weight).

CONCLUSION

Of concern in the pilot project was the general weakness in both governance and finance management regardless of where a GBV CSO was situated. While it was very strong in the final study investing in a tool that informs the need for targeted trainings to meet these shortfalls represents a leaner means of resource allocation. Next steps involve tailoring a training module that addresses these core performance areas, together with the development of a mentorship programme that pairs underperforming CSOs with stronger ones to create essential networks to ensure continuity of programming. These approaches may offer viable solutions to sustainability challenges.

This presentation was encompassed entirely by the PowerPoint presentation and there are no additional notes.

Venessa: announced that they will not take questions as the conference programme was running late. There might be time after lunch for questions.

12:00 – 13:00 Survivor Stories

Panel of survivors are identified by the initials X, Y and Z. The delegates were asked not to record or film the survivors as their confidentiality must be preserved. Venessa expressed that the entire conference wanted to thank the panel for their courage in being PrEPared to share their stories.
Survivor X
(The survivor spoke in her mother tongue and an interpreter translated for the benefit of the plenary session)

Her partner would abuse her and would not allow her to go out or to go to work. In September he began to be more aggressive. He would take things like the fan, or kitchen implements, and use them as weapons to hit her. She ran away from him, and her partner was very angry about her telling the neighbours of the assaults. She called the community workers to assist her in the issue.

People did not want to help, and the landlord and her neighbour forced her to sleep in the house, despite the abuse. She had no support or assistance, so she could not fall asleep as she was afraid for her life while she was in the house.

A social worker from Future Families assisted her, they consulted her and then they went with her to the police station for a protection order. Since then she has been staying with her sister. She does not work and neither does her sister. Previously her partner was buying the medication for diabetes and now she cannot adhere to this medication.

She also has a child that was conceived through rape when she was 14, she was stigmatised because of this and has no child support because it was a child of rape.

It’s only her that must make the decision to emerge from the situation and she has decided to do this. She knows it will be hard, but she is determined not to go back to her abusive partner.

Survivor Y

I was orphaned at 2 and adopted 5 times, during which time I was abused, raped and even burnt. I decided that I had to change my own circumstances. Throughout my childhood, if I was alone or working in the house I would be sexually abused.

In silence I would cry, and the hate would grow so strongly that I couldn’t love. I started hating very hard and left to live on the streets in a park in Cape Town. I was still attending school but at school they didn’t know this, and homeless people cared for me. I would put on a mask to hide my hurt. All I knew was learning to survive. After many years, circumstances forced me to get out of school and I worked at a factory, just to eat as I did not have education. I knew there was something better waiting for my life, there was always something driving me forward. I knew my late mother wanted more for me. While I was working I became a designer by asking them to take a chance on me. I believe a higher person was taking care of me.

I left SA by becoming a singer and I am still a singer. I earned a lot of money while I was still below the age of 21 - despite all the pain and hate inside me. You can imagine what a young girl would do with so much money. I made many mistakes and I built a wall between myself and others. Finally, I had a boyfriend who courted me for 9 months. The first time I saw a
penis and realised that I had blocked what had happened to me when I was a child. All the years came back, and I understood what had happened. I went crazy in a way. I lost someone who loved me because I didn’t understand.

I could smell and see the faces of the people who hurt me and where they did it. It was time for a journey of self-healing, to apologise and love myself and heal. All I wanted was for them to admit and say sorry. They did not. I forgave them anyway and set myself free and could move on with my life.

Now am working with Lifeline to help people who are broken, and I am working for the change that is about to come.

**Survivor Z**

Thank you to my sisters who shared their stories. I greet you all in the name of Jesus who saved my life.

I was born in Umtata and at the age of 14 I was raped and shot through my left ear. I should have died but the bullet did not kill me. After the man shot me he tried to get rid of my body by pushing me into a pit latrine, but my shoulders stuck, and he could not get me into the pit. He left me for dead. I told myself not to move because I felt he was there. When he left, I managed to free myself from the pit. I tried to walk but was too weak. I crawled to my uncle’s house and the gate was not locked as they usually were. The dogs bit me, and I could not protect myself. The people in the house heard the dogs attacking me and they rescued me from the dogs. I asked them to give me paper and pen before they took me to hospital as I was determined to write the name and what happened. The ambulance took me to hospital, but they could not remove the bullet because I could be paralysed or die. The man was arrested and sentenced to life imprisonment.

I needed to leave Umtata and find my mother, and I went to Cape Town to look for her. I lied to the driver that my mother was going to pay the taxi fare. I only had 8 months with her before she passed away from HIV. I needed to be on my own. I went to Tygerberg and to see the social workers alone. So much was going on in my head that I tried to commit suicide, but I failed.

I went to study at False Bay College but couldn’t cope with the pressures and it was here where I was referred to the Rape Crises Centre and received counselling for the first time. I got the courage to talk and started going to prisons to share my story. I wrote a book and a letter to my shooter. My aim is to save women who have not yet started to talk about rape – to encourage them to talk and get free. Rape is not the end of the world. You need to be strong and positive.

I decided to go back to the Eastern Cape to face my perpetrator. He agreed to see me, and I went with Antje Krog who helped me with my book, they asked me to tell my story and ask questions of the perpetrator.

I needed to ask him why did he choose me and what did I do and if he remembered me begging him to forgive me for whatever it was that had made him do these things to me?
He showed no remorse – he said he was in prison and what did I want. I told him it was nothing in comparison to what I was going through – and I said I forgave him.

What I want to say is that no matter how hard life can be, and I am still going through difficulties, I will stay positive and stay strong and will never stop thanking God. I advise young women that being raped shouldn’t stop you to be what you want and to reach your goals. I realised that my childhood was poor and deprived and how I didn’t know my mother. I never visited my mother, I never had fun with her. This made me sad; it was trauma after trauma. I often felt I wanted to die. But I realised that rape is not the end and I chose not to be defeated. I am glad to tell my story and change lives and to face my perpetrator and forgive him and for him to see what he did and that he realised that this action also destroyed his life.

My hope for women is to be treated as human beings. I salute all women, we are not the victims we are the true survivors.

Venessa: we honour all your courage strength and resilience. These stories put into perspective what we have been discussing here. We wish everyone strength.

13:00 – 14:00 Lunch

Questions

The afternoon session began with one round of questions for the earlier panalist.

1. Valdi mentioned challenges with schools allowing admission for working with learners. Sometimes they speak to management without parents. Have the researchers taken time to design something to educate parents, management and teachers before going to learners?

2. The questioner was struck by the relevance that they need to think differently when trying to end GBV. They need to look at different information that can interest corporates to provide funding. Kempie – really interested in programmes that capacitate young people and know that there are a lot of other groups who have done the same sort of work. Can they perhaps pool these resources and data to get a better picture?

3. What is the accepted norm in the community that these elevated levels of violence are now part of what happens there? How does the normalisation of violence influence the violence experienced by victims of GBV? A lot of these cases are in communities where violence is an accepted norm, and this is assumed to affect the reporting of GBV.
4. Valdi mentioned that the emergence of abuse to the boy child. It is an emerging tendency and the tip of the iceberg. It comes from a slightly different perspective to the girl. Seeing that the aspects differ what did you do to address this before you began your study?

5. Valdi – what reports were provided to school considering confidentiality?

6. Is it viable to screen in a group as people will possibly be intimidated?

Answers

Valdi van Reenen le Roux

Entry to schools was one of the challenges. Initially they sent the project leaders and then realised that rank means everything, so Valdi had to go and meet with them. That helped tremendously. Sometimes they would be asked to meet with senior leadership. That was when they would speak to violence and its impact. They needed schools to realise this was not about meeting targets but rather what the school needs. Many principals came forward to ask about issues like GBV and drugs and to establish levels of trauma in schools. Once they understand that the report will be in their interests, they get buy in. Beyond the screening, they also provide a counsellor to help with the wounds that are reopened. They can’t have SAW doing that, which meant counsellors had to provide the follow up. The bottom line is to meet with principals and senior staff to emphasise the gains for the school. Through that they also said that they have no problems with parents approaching them – usually this will mean the principal will help with the parents. Meetings are in the evenings, which is after hours, but they give buy-in. Then all that creates an issue is a reluctance from teachers to release the children from their teaching programmes.

To encourage that they give the teachers pampering sessions which allows them to do a debriefing and gives them an opportunity to talk through the challenges. They try to do a quarterly debriefing, but it depends of the context and politics of the school, which can impact on the intervention.

Normalisation of violence

There are houses where children are lured to come to and eventually end up selling drugs, or sex and drawn into human trafficking. This form of ‘normalisation’ affects reporting.

In communities where you have poverty then the gangs get involved in things like electricity provision, crime reporting, getting food. It becomes accepted to work alongside the gangs, which has implication for how sexual violence is seen in the community. Which is where they see the culture that the women who are related to gangsters are expected to give their bodies to the gang. Also, gang life is inter-generational. They have seen that gangs are now becoming more and more violent,
from generation to generation. New gangs were started but there is still an acceptance of and affiliation with gangsterism.

Therefore, they are anti the army coming into the area. Gangsters are part of the community and known to the victims. When the army comes in, these perpetrators stay at home and they find an upsurge in home-based GBV and IPV. These gangsters are not making money and they then take out this frustration on their partner.

Boy child

It is precisely this reason why they are lobbying for a commission of enquiry in the WC. To date 69 children have been murdered and they need to determine what information they are missing out on and think through what needs to be changed. Valdi is lately questioning why the woman must leave the home, why the children must leave and yet there is no shift in the behaviour of the perpetrator. Perhaps they need rehabilitation centres for the perpetrator to go into, rather than taking women out. The Commission must lead us through the programmes they need for boys – what they are doing has not had the desired impact.

The report is confidential. They do not give the schools the names or details of the learners, nor do they give them statistics. They give an analysis of categories of violence and then give recommendations. They are very careful not to become a crutch for the school. The organisation cannot be the ‘all’ for the school. They encourage them to think around campaigns as ways of addressing the issues. If there is a high level of trauma, they will put a counsellor there and the school provides a liaison, who works with the teachers and learners. When they do screening already pick up on levels of trauma within a school and community.

They don’t like screening in groups but don’t always have the time to do otherwise. They need to find ways to speed up the process. It is not ideal, but it is one of the challenges they have. They have a different way of implementing the individual data and are very careful of how group screening works.

Kempie van Rooyen

They have come to realise that research should have been how to get principals involved. They have realised that these kinds of gatherings (this conference) help to create communities of practice. Sometimes they miss key role-players. At a school GBV is only an extra. Similarly, at SAPS and DOH – primary core business is not GBV.

A lot of work can be put into the ways to work within schools.

Collaboration is present in pockets. Usually they don’t have time to spend on creating communities of practice, and often the things that they miss are management issues that will make us more effective. Freely accessible resources to help planning with projects, a “what-works” resource library could help a great deal with this.
One thing they could use is a central database of who is doing what, and where, with whom. If there are companies who could assist with this sort of project, that would be valuable. This can also assist with collaboration. There is a need for remote access for sharing information.

Venessa thanked the panellists for the perspectives they raised and the delegates for the questions which further illuminated the conversations.
14:00 – 15h00 Panel: Youth Perspective

Teenz Alliance in Ending Sexual Violence in Schools

Palesa Mpapa – POWA

ABSTRACT

In a 2001 report, Human Rights Watch found that sexual violence against girls “permeates the whole of the South African education system.” In 2006, the South African Human Rights Commission noted that sexual violence, including abuse perpetrated by educators, was one of the most prevalent forms of violence identified in its hearings on violence in schools.

It is on this basis that POWA and ADAPT realised the need to address sexual violence in schools. The two organisations believe that interventions in the context of sexual violence in schools can produce truly effective results. ADAPT has expertise in engaging with boys and young men on issues relating to gender based violence. A programme that will assist both boy and girl learners in addressing sexual violence in their respective schools was developed and implemented.

BACKGROUND

Violence against women and girls does not only affect them as individuals, it affects the families, communities and the country at large. This has a far reaching effect on the individual’s achievement of their goals in life, the girl’s performance drops in school due to violence, others drop out of school especially if perpetrated within the family and they reach a level where they do not cope any longer. This results in the current situation where most women and girls lack skills to access the employment market and most of them are locked in the cycle of abuse.
KEY INTERVENTIONS

• Girls are empowered to advocate for the reduction of sexual violence in their schools;
• Leadership training for the representatives of the girls and boys clubs;
• Advocacy and awareness campaigns led by girls and supported by boys;
• Girls accessing quality sexual violence services;
• Community dialogues on sexual violence issues in schools are held;
• Community action teams collaborating with community policing forums to develop safety protocols to prevent harassment of school girls on public transport;
• Boys respecting and relating with girls as equals.

SUCCESSES

• A strong relationship with the Gauteng Department of Education has been established.
• A strengthened psychosocial service for both women and men.
• A strong stakeholder relationship with the community based organisation on sexual violence, DOH, NPA, DOE and local government.
• Implementation of after-school sessions about sexual violence issues.
• Partnership with community radio stations were learners could create awareness about sexual violence issues occurring in and out of school context.
• Peer educators developed a Code of conduct on sexual violence aimed at addressing sexual violence levels in their school.

CHALLENGES

The delay in approval by the Gauteng Department of Education to allow us to conduct the baseline in schools.

LESSONS LEARNT AND RECOMMENDATIONS

The involvement of civil society organisations in schools is important to address social ills, low performance and learners' retention.

The program should be rolled out in all the provinces.

The DOE should financially support the program as it enhances the implementation of the department’s policies for quality education.

This programme works in 12 schools in the Ekurhuleni municipality.

A variety of incidents that highlighted offenses against children including cases against boys and girls and an incest case where a minor was a victim led to the study.
TARGET GROUP

They discovered that a safe environment is critical and often schools are not found to be safe.

Most schools do not have SW and even if they do they are overworked and cannot cope. They can only attend cases which are emergencies like suicides and so on.

SUCCESSES

Leadership camps led by peer educators.

Campaigns are usually implemented soon after leadership camps. This is because they receive many resources to help with such campaigns from these camps and a lot of information which they need to deal with sexual violence.

SW have good relationships with the TCCs near them and are available to the learners who need their services.

9 Community dialogues have been held.

Stakeholders forums include government and civil society in both Thembisa and Evaton.

What worked is that they first approached the Gauteng Department of Education, which made it easier when dealing with schools should they want to implement programmes. Then there is a smooth transition. They hold after-school sessions, but they don’t do this in the final terms since the learners are writing exams. This way they work with and understand the priorities of the teachers and parents.

At the camps they work with the Gauteng Department of Education and the educators who participate can also support and spread the word.

The baseline study was a challenge as there were a lot of procedures they needed to go through. It took a year to get permission, to ensure the safety for the children. As the project is a 5-year one, they could show that they are not just doing research but are also involved in the provision of services and counselling. So, this helps the schools and the teachers as well.

Various therapies are included, including art and play.

A FEW CONCLUSIONS

They have learnt that sexual violence is experienced but disclosure is a problem and they need to address this. Communities have a loss of confidence and trust in the SAPS which can lead to vigilantism. There is a lot of incest experienced yet in the
survey there was a problem identifying it; parents want to conceal this. It is frequently
the step-father who is the perpetrator and often it is the mother’s economic need
to maintain the status quo and it is difficult to expose. This also told them there is
another area where they need to disseminate information. The suffering of the whole
family will result if they report it.

LESSONS LEARNT

Difficult to engage the Education Department on the issue of the study; it took a
year. Counselling is essential to education and they have been able to show this.

Venessa thanked her saying that was an example of a holistic approach which
involved all the role-players.
I am the Future
Simpiwe Nontamo, Tandolwethu Community Development Centre

I am the Future, is the cry of a 14 years old girl, who was forced to marry a 48-year-old man. The girl was not aware that she was taken away to a man’s house when her mother ordered her to accompany the man. The girl has two siblings, 10 years and 12 years respectively. On this day, she was told not to attend school because the man was going to visit her mother to arrange this barbaric activity.

After they reached the man’s house, he started raping her, beating her and threatens to kill her if she can try escaping. She was raped several times until some community members became suspicious and report the incident to the police, who took her to the local hospital, where it was discovered that she was HIV positive and pregnant.

You can feel her words ‘I am the Future’ why destroying me, what did I do to deserve this, tears rolling on her face, looking hopeless, pregnant while girls her age attend school. Forced and arranged marriages are the worst forms of abuse that destroy the young girl’s self-esteem, and their confidence. Sometimes they are called names in the communities. We need to #enditnow!

BACKGROUND
This practice happened long time ago and by the look of things it was right for those generations that practised it and they saw no problems with it as some were taking it as a ticket to get marriage. Indeed, there was no problem because every woman was so proud of getting married. It was done in a right manner, and both families would sit and discuss lobola and other presents. Nevertheless, today, bearing in mind that there are HIV, STIs, and other sexual infections, forced marriage is a crime. It violates one’s dignity, girls are not free to choose and do their daily routine as girls. They are denied a right to go to school and other activities girls of the same age do.
KEY INTERVENTIONS

While I was a stakeholder I saw that Government, and other relevant key stakeholders are doing all they can do to end this practice. There is a community of Cele at Flagstaff where this practice was done, but after the intervention of government and other key stakeholders, there was no more incidence of Ukuthwala, as it is known.

SUCCESSES

The engagement of community leaders, religious and political leadership through community dialogues, brought successes to the end of this practice, and today it is no longer as popular as it was before.

CHALLENGES

Many challenges force people into this practice. Unemployment, poverty seems as a form for other parents to see an easy way out of poverty, by selling her kids to older men and take the money. They do not care what will happen to their kids as long they have money. I think we still need to hold dialogues where we will discuss these issues and make sure we end this barbaric practice that kills our young girls. Sometimes the survivors experience stigma, and victimisation in the community. Other factors including inadequate investigation and evidence collection means the rate of convictions and prosecution are low. Police will claim there is no evidence, yet the incident occurred.

LESSONS LEARNT AND RECOMMENDATIONS

Men must be taught to respect women and girls. Men must take centre stage of manhood and be protectors of families. Men must be providers of security and women must be thought to respect their children. They must not see them as tickets out of poverty. I recommend that government must re-align its laws and introduced a heavy sentence for perpetrators and police officers must be quick to act to any violence meant to destroy some people’s dignity.

He began by saying: As we gather here please remember that October is cancer month. I have been groomed and educated to be a programme director.

Note that this presentation was identical to the PowerPoint and abstract and no additional notes were made.

Venessa said that all hear a lot of terrible things, but the conference has seen that work is being done to make a difference and change practises.
Questions

1. Observation – Boet Simpiwe I am concerned with the reinforcement of patriarchy by the comments in your talk.

2. Question to Boet Simpiwe – please elaborate on how women see their children as a ticket to money, the language is very patriarchal. Men are the ones who arrange the lobola.

3. Comment – Why was research concentrating on high school? Given the level of maturity of young people, they mature from primary school, should they not take the programme to primary school? Children are often already engaged on sexual activities at primary level.

4. Simpiwe was thanked for his work and the delegates enjoyed the success of community based interventions. In August discussion on TV spoke about how Ukutwela was rife – what are the chances of replicating the model elsewhere?

5. Palesa of POWA was asked if she planned to expand the programme to other provinces and when?

6. Palesa – POWA was very powerful in its legal department in 2000s. Is this POWAs core business and does the legal department still provide aid to rural organisations?

7. Simpiwe was told that his talk creates confusion by giving stereotyped approach. This is a dynamic problem and the perception created does not help as they need to review and make proposals to help other places.

8. Palesa – can they consider the TVETs and community policing? Trust relationships can be developed from getting the community involved.

Venessa thanked the delegates and that she was grateful for the honest pace where all can speak to each other respectfully and honesty. She commented on the issue of maturity saying that just because young children are engaging in sex does not make them mature. Let us all be careful to use words carefully and not ascribe meanings to them which are not accurate.
S impiwe
It is understandable that forced marriages do happen but in this case, he said he was relating the story of a 14-year-old girl. It is very difficult to end it. It is rife in the Eastern Cape. In this instance there is a case where women arranged these marriages behind closed doors, which as why he spoke that way and he is grateful for the concern. Sometimes women are involved which is why he said that women must respect their children.

The organisation is still young – 9 months, and he appreciates the chance to speak to all.

Palesa
There is a good response from the learners and teachers and the department; the problem is the lack of time while schools are open. They all see the importance, but the problem is always funding. Government sees a good initiative and applauds it but is not willing to put resources into it. If they expand it as you suggest they will not have resources. After 2019 the alliance, which is currently supported by Comic Relief, will end. Soul City works with primary schools. Expansion beyond 2019 is an aim.

POWA used to have a direct legal services department but funding became a challenge. The Government funds legal services through legal aid. They had to decide what they can offer, what they can use resources on, and they do offer strategic legal cases for under resourced issues. Now they have shelters and psychosocial service centres where they offer counselling. They have women’s writing programmes as well. They also have a training department which is also underfunded. They offer capacity building to new organisations.

Funding remains an issue and through other programmes they will develop these relationships. They appreciate the contribution regarding adding research from the police. They do work with them and get their views to see what will work since there is so little trust in the police, this is often a severe challenge.
Media reporting on GBV & HIV

Sophie Hobbs, NACOSA and Sultana Mapker, Voices 360

BACKGROUND

Although there has been substantial reporting of South Africa’s GBV problems – most recently in response to high profile murders of women by their intimate partners – much of the coverage is sensationalist, potentially triggering and often cites inaccurate statistics. The media in general have little real understanding of the issues and sensitivities involved in reporting on sexual violence and there is virtually no reporting on the link between intimate partner violence and HIV. So, while the public are aware of the issue – as a ‘crisis’ – they are not well informed of the extent of the problem, the underlying causes and what is being done to prevent and respond to it.

The pressure on newsrooms and the fast pace of the news cycle means that civil society organisations are not equipped to advise or comment on GBV and IPV stories. There is also a concomitant lack of knowledge and capacity within CSOs on how the media works.

DESCRIPTION

NACOSA is a network of over 1,500 civil society organisations working together to turn the tide on HIV, AIDS and TB in Southern Africa. NACOSA promotes dialogue, builds capacity with accredited training, mentoring and technical assistance and channels resources to support service delivery on the ground, particularly among children and youth, key populations and women and girls. NACOSA’s Gender Based Violence programme, funded by the Global Fund, is a national response to unacceptably high levels of gender based violence which are fuelling HIV. The programme includes an advocacy component to increase awareness of, particularly, intimate partner violence.

Voices 360 is an online public and event platform that facilitates opinion and knowledge exchange. Given that contexts are marked by complexity and diversity, Voices 360 presents an opportunity for individuals from a range of disciplines to use their knowledge, energy and ideas to make a real difference. It is a chance for ordinary citizens, youth, thought leaders, captains of industry, academics, writers and policy makers to express and share their perspectives to inform and contribute to policies, development goals and emerging issues. Voices 360 is an affiliate of the Independent Group which means information has the potential to reach various print and digital media platforms.
Working together, NACOSA and Voices 360 will investigate media reporting of GBV and its link with HIV (or lack thereof) and provide practical advice for organisations to develop good relationships with media that sensitize them to the issues.

RECOMMENDATIONS

- Identify sympathetic journalists and develop relationships with them
- Build a library of stories with photographs to send to media when a news item is current
- Find out what journalists and editors need and write stories that will engage them
- Train your staff to be sensitive to the issues surrounding survivors and their stories – help to educate the journalists and content producers you are in contact with.
- Collaborate with other organisations doing similar work – complement their stories; and they can complement yours.
- Build a strong social media platform – especially on Twitter – and push your stories out to journalists and opinion formers.

The presenters emphasised that they are practitioners not experts but they wanted to chat with the room about social media and how it can help your organisation and the overall goal.

Notes on PowerPoint Presentation – Sophie Hobbs

GBV is reported but there is a serious misapprehension about it in the media and only the most brutal cases are reported. It is sad since other important stories are missed. They don’t have good statistics and don’t know the scope and often reports are without context. Much of the reporting can be very triggering for survivors. This can be a repeat trauma. Much victim blaming takes place and passive voice is used ‘She was raped’ rather than ‘He raped her’. Pointing this out helps readers to think about how they phrase stories of IPV and GBV. Often, they are bleak and hopeless. It is a deadly serious field, but it is not all doom and gloom. Often media reports are not about survivors or of the excellent work and the amount of work going to combat GBV. As activists they can begin to feel powerless and that does not help. The link to HIV is also often underreported. The How not the Why is often reported. Not a lot of research has occurred on this reporting but there is the following report on a Bosnian study. Interestingly, Bosnia and SA are also post conflict societies.

What stands in the way of the voices of experts coming out in combatting GBV?

- Lack of capacity - a luxury for services providers
- Lack of understanding of the news cycle - they are unresponsive and need to get very involved in getting stories out
- Lack of resources and
- Not consulted.

Result: The public is not kept aware of what work is being done. Some of the facts presented are not true and there is in addition a lack of research into statistics.


When using local resources – get local people to provide information and assist in the reporting.

International Journalists websites – use the available information which is in the public domain, to make your message more effective.

https://www.icij.org/

**Notes on PowerPoint Presentation – Sultana Mapker**

How many people in the room send pieces to media houses? There was not a large response.

Basically, sending a piece to a media house is a huge task since editors receive messages asking for requests all the time. So much information goes through their desks and the problem is that many items get missed because there is a lack of capacity, and not enough reporters, and juniors don’t have skills. When an organisation does send a piece, it does not get a response because there is often just not the capacity. Often a piece will be published, and then they don’t know that either. (She suggests all read the newspaper every day.) Sometimes a great piece will be cut because there isn’t space.

There are things that can be done to make a story more appealing and more likely to be used.

- Know the audience and who they are sending something to. Fit it to who they are writing for. Find out which unit deals with development or where they classify GBV.
- Best time to send is in the morning as print media only layout a bit later. They will have a better chance before 11, especially Monday-Thursday.
• Do a follow up call as that may make them more likely to be interested.

• Often, they are not using a language that is accessible and editing not always possible; always write jargon free and in a way that the person outside the sector can understand. Often, they are very passionate and then they rant rather than giving meaningful or constructive input into the matter. If they are aggressive and not solutions-based they will exclude it. Be strategic so that it can go to the wider public. The biggest challenge is that the tone of a piece can exclude it from publication. Work on the tone.

• Also, it is good to attach a photo of an issue, obviously excluding confidential matters, as this too makes it more interesting and easier for the editor to go with your story – it has instant appeal.

It’s a promising idea to develop a set of articles that can be used to comment on a matter which reaches the news cycle. Do not duplicate work but tweak one of these archived resources to make it more relevant to the news of the day.

Keep them between 750-1000 words to avoid editors having to do any cutting. She suggested that they control what is included or is kept in by writing what they want to be included. Editors are not always aware of what is the most essential aspect of a story.

Voices 360 is an opportunity to give everyone a platform to voice their opinion. The difference with this platform, which is an online platform, is that print media is also involved as they channel it to editors across the country. Initiative intends to generate debate and start open spaces where communication can be shared rather than being kept in-house.

They were there to present this platform to all and to extend the platform to allow them to keep it on their radar. They include anything that will add value to the public and public discourse. www.voices360.com

They suggest organisations find clever ways to use what they currently have. It is important to share information – cross-pollination of information adds to and deepens the knowledge base.

The digital space is the quickest way to get information out there. Content is King remembering that what the quality of what they have written is the entry point to all media outlets. Also, it is important that is readable.

They encourage all to follow twitter and social media and to use it. It has democratised access to media. There are many, if not most journalists who are on twitter and who get most of their story-leads from twitter. The nature of the newsroom has changed because of it.
#metoo example was cited which has sparked the interest of the entire world. See:


Venessa thanked the panellists for their input and for helping the delegates to get an inside view of the world of news, which helps us to use the media as a part of everyone's activism.
9:00 – 9:30

Welcome

Zarina welcomed all and particularly Dr Maureen Van Wyk (NACOSA) who was present for the entire day.

Claudia dealt with housekeeping.

The conference organisers announced that they will be developing a list of recommendations and conclusions and all are urged to contribute and participate.

Dr Maureen Van Wyk

She welcomed everyone and hoped that this has been a useful conference. What is useful and important is that, so many practitioners were there, and the conference has launched the website, which includes more than 70 organisations. Also valuable were the Shukumisa survivor stories of day 1 which brings all back to why they do the work they do.

She thanked the task team for the programme and the work that has gone into this conference.

Many are aware that Sharon has worked so hard despite difficult circumstances and she thanked her from everyone present. Also thanked the Global Fund for the opportunity, they are humbled by the work being done in SA. She urged that this not allowed to remain a talk shop. They need to integrate and take collective action that the resolutions are followed up on; so much expertise and goodwill exists in the room that if they address the problems of GBV and HIV they cannot but succeed.

We must mobilise the resources and #enditnow.

Zarina thanked Dr Van Wyk for reminding them of what they are here for.

Recap of day 2

Venessa did a brief recap of day 2 and welcomed all to the third day of the conference. They had a full programme on day 2.

Claudia in her key-note address presented research on shelters in 4 provinces, that services must be available to all who need them and should be more than a legal priority. During the plenary Megan of SAFFI which works with faith communities, spoke of how patriarchy can be disrupted, how dialogues are beginning and the challenges and successes in this area. Maya Jaffa spoke of the vulnerability of female sex workers and poly victimisation. Concerning stats were presented and variety
of traumas described. No section in clinics specifically addressed violence. The delegates highlighted the needs of women in shelters and sustainable livelihoods. No research work on children of sex workers exists, a world-wide issue. The second panel of Kempie and Valdi discussed ongoing research and long term studies. They reminded us of the challenges of working with schools, trauma screening and learners and teachers that were ignorant and needing support. They spoke of the complexity of people living in gang communities. Aiden described a tool for civil society to make the work more effective. Karin reminded us that corporates could work alongside civil society and support it. They heard survivor stories that reminded us all why we do what we do. They saw how support is sometimes not present and leads to the isolation of victims and learnt the importance of forgiving and setting yourself free. Youth perspectives from Teen Allianz and POWA spoke about the work in schools and with parents. Simpiwe from the Eastern Cape spoke about Ukutwela and a small example of success there. The last session was on media and gave us a great deal of info about using the media and making stories accurate. That old statistics can become facts; avoid blaming victims. They reminded us to understand the news cycle and the way the media works. They also discussed the Voices 360 project which is a forum available to all and stressed the importance of using case studies when writing stories for the media, given the power of media to continue advocacy. Evening events included the launch of the Shukumisa website and the Shadow Framework.
ABSTRACT

A range of measures have been introduced to improve the experience of rape complainants in courts. These include dedicated sexual offences courts, along with various hybrid versions of the model, specialised prosecutors, and case managers attached to the Thuthuzela Care Centres. Drawing on interviews and a series of observations of rape trials conducted at regional courts in Gauteng, this presentation describes these various models and approaches in theory and their application in practice. It sets out a brief typology of these various measures and outlines the infrastructure, equipment and facilities available to each, critically considering how these affect the functioning of the various models.

The paper then considers how institutional factors such as workplace performance measures also influence how rape trials are managed. In 2016/17 the estimated conviction rate for sexual offences was 69%, with this figure also set as the conviction rate for 2017/18. The estimated conviction rate for “TCC reported cases” was 67% in 2016/17, with this same target also set for 2017/18. Prosecutors in the study signed performance contracts in which they committed to achieving a 69% conviction rate in sexual offences cases. This was in addition to the requirement that they finalise fifteen cases per month. As the presentation shows, these targets influenced prosecutors’ selection of cases for trial, their preparation of witnesses, and the approaches they took to leading rape complainants’ and other witnesses’ evidence.

Performance measures are not irrelevant and certainly have their place within the overall scheme of things. However, the centrality they have assumed in the courts is having unintended and perverse effects. The emphasis on number potentially turns justice into a “factory” or “veyor belt” and reduces complainants to statistics who either contribute to, or detract from, prosecutors’ merit awards. The targets may also be reinforcing and reproducing rape stereotypes. This is because they encourage prosecutors to focus on those cases that uphold conventional notions of ‘real’ rape – that it is violent, results in injuries and typically takes place between strangers. Cases that challenge these conventions, but which are also more time consuming (even if potentially winnable) are thus less likely to be tried and complainants not provided with the opportunity to tell their story in court. This may be efficient, but it is neither effective nor equitable. The prosecution of rape requires a very different approach to measuring performance, one that is better attuned to the more qualitative and substantive dimensions of justice. This will be crucial to ensuring that targets do not undermine the effectiveness of specialised measures for rape complainants whose matters go to court.

The findings are available here: http://www.mrc.ac.za/gender/RAPSSAreport.pdf
Lisa began by saying that it sounded like the previous day was largely about community but in this discussion, they are focussing on the law and the state, which is more difficult.

The findings from research are over 18-month period, looking at prosecutors. They were trying to understand the process of why rape cases fall out. Why do only 8% succeed? What happens to the other 92%?

**METHODOLOGY**

They went and sat in the courts and this gave a valuable perspective. They often had interesting insights into tactics of prosecutors. They spent 18 months at 6 courts, observing. Most were hybrid courts and general courts. This meant that prosecutors were a mix between those who were experts and some who had no special skills in sexual offences. They sat in court and spoke to the defence, prosecutors and magistrates, and ultimately these details informed the questionnaire which they developed.

Control prosecutors direct the flow of dockets, then actual prosecutors work with the information contained in the docket.

She pointed out the difference between the National Prosecuting Service (NPS) which prosecutes and the National Prosecuting Authority (NPA) which makes policy decisions. It is a dynamic and there can be tensions between these two divisions. These prosecutors would work with the police and were a first step in the process. There can be up to 5 different prosecutors making decisions about whether a case will proceed, and how. Law is often based on interpretation and different points of views can abound. Each one who interacts with a matter can come up with a different idea.

That is why they see cases where the prosecutors who did not make the decision, now must prosecute.

**WHAT IS A COURT CASE?**

Without these things you don't have a court case. Without one of these you cannot continue. This also shows the level of control that prosecutors have in the court process.

**Documents** - the docket must be at court and complete or 'ready for trial'. That means that all evidence and DNA is available.

**Equipment** - with children there is usually an application for evidence to be given via CCTV, transmitted onto a screen so that the face and importantly, the expression on the face of the child can be seen in the court. That equipment often doesn't work. At one site they were doing all children's cases from the areas and all the other cases as well. Overload of matters is common, and prosecutors are always dealing with a big volume of cases. If the equipment doesn't work, then the cases cannot proceed.

**Subjectivities** - belief of how case should be dealt with, why rape happens, the idea about accused and so on.
**Procedures** – the law and the process associated with what the law says about that. Many processes impact the way cases are dealt with.

**Practices** – how the court is informally managed. Practices is what she wanted to focus on in this discussion.

It must also be in time and space and have a context.

We discuss the need for specialised courts but it becomes obvious there is no space at the courts – this is commonly not available and if there is no space, they cannot offer specialised areas for specialised cases.

The most equipped court they saw during the study was the specialised court at a courthouse which had the space and the necessary equipment and offices. This was an exception and different from most cases and courthouses.

**Volume** – what is the case load that would be dealt with in the time available? Any delay would affect the number of cases to be done in a day. This influences decisions.

**PERFORMANCE AGREEMENT**

Prosecutors sign a performance agreement which sets out the basis for what is called a merit award. This agreement places great pressure on the prosecutor who must perform to achieve the required statistics and to earn the merit award – which is a bonus basically, dependent on the achievement of certain numbers.

Research indicates that ‘convictability’ drives prosecutor’s decisions.

Memories and identification can be problematic where the rapist is a stranger and in cases of alcohol consumption by the victim. Prosecutors while they might want to proceed, will be hesitant if there is evidence that will cast doubt on the victim. They cannot afford to take a chance, even if the victim may be an excellent witness who is believed by the court, they must weigh up the potential that the evidence will be doubted, in cases of alcohol, or where there are no injuries.

Sadly therefore, injuries become essential as they can make the case stronger. Some prosecutors mentioned that they prefer cases where there are serious injuries as this makes the case more likely to succeed.

Legal Aid board attorneys are also subject to stats although they are different. They commented that some prosecutor’s stats are so high because the cases get withdrawn. If you don’t go ahead with a case that’s because it is a waste of resources, which are limited, to proceed with a poor case.

This seems to push prosecutors to encourage accused to plead guilty, but the sentencing component is then not done in terms of the letter of the law. An informal bargaining takes place.

Performance indicators slide was shown.

She said that all prosecutors need to have a relationship of trust with the complainant.
Notes on PowerPoint Presentation – Lisa Vetten

Slides - Quality of testimony

‘If you don’t do anything in a day, then they question you about what you have been doing’.

While some cases will be finalised in fewer days some matters take far longer. This all puts pressure on the prosecutor as stats are not true reflections of the work that is being done.

If a case is complex, it takes longer to get the evidence out of the witnesses and the amount of evidence can also take longer. This means you are not meeting the required stats and this can affect the quality of testimony. It is important to remember that the way you speak and testify makes a difference in a rape case.

Basically, the prosecutor is under pressure to put through the stats and finalise matters, without thought to the quality of the work which is done.

Slide – The effect of stats

The tragedy is that talented committed prosecutors are lost because they cannot sustain the pressure which the system puts on them.

Slide – concluding questions

‘Targets change the way you work because you have to meet a target. How do you meaningfully measure justice in terms of stats? Some cases are 50/50 but the complainant still wants to proceed, or they may be quality witnesses.’

We can contribute, but the number of convictions becomes value in the form of money or a bonus for the prosecutor. An audit culture focusing on results. They need to consider what policies it results in if you are chasing statistics without thought for other aspects.

She urged the delegates to diversify their approaches to funding and to the work they do. She has already heard that the Government has asked for an IMF loan and the history of such loans is that specialised services go first. This will mean specialised courts and expansion of the limited offerings now available will be unthinkable. Housing social services and specialised services are not priority. The Government has frozen posts, which may mean the condition will not get better. They need to decide where are we going to put our energies?

Zarina thanked Lisa, commenting that it was a depressing note to end on but that the presentation had great insights into why cases are not prosecuted. The study allows us insights into the complexity of prosecutions. Is it access to justice or are they looking just at numbers?
Call for a National Strategic Plan for Gender-Based Violence

Rakgadi Mohlahlane, Stop Gender Violence Campaign

We launched our plan and are going to be passing it on the office of the Deputy President.

The National Strategic Plan (NSP) has been a long journey for all of us who have been involved.

When producing the plan we imagined that we needed to have a State that is held accountable and has the resources and can commit to understanding what works and what doesn’t. We imagined a scenario where all role-players came together to keep society safe and to understand how it functions.

Civil society must mobilise and hold Government accountable, we are grateful to find a home for the framework. We need to continue to ensure resources are available.

The slides presented, and address were largely the same, and were an introduction to the plan. The reports are available through the End Gender Violence Campaign and were also available in hard copy at the conference.

Re-imagining a Human Rights Model to address Violence against transgender women in South Africa

Kapesi Antony Chakuwamba, Researcher & Human Rights Activist

ABSTRACT

The main purpose of the research was to explore violence against transgender women. The main objective of the research was to highlight and understand this violence against transgender women in South Africa. The study adopted a qualitative and quantitative approach. Focus group interviews and surveys were conducted to collect the data. The study also relies on secondary data such as a review of literature and other related documents and reports to get insight on violence against transgender women.

Various findings emerged from the research. The research indicated that transwomen suffer violation in health and well-being. They are being refused medical care at an alarming rate despite the international obligations that everyone has the right to enjoy the highest attainable standard of physical and mental health. The research also highlighted that an overwhelming majority of transgender women have survived an incident of physical, psychological and emotional violence. The research also proved that violence against transgender women comes in a variety of forms. Most of the research respondents indicated that they experience violence through the community or institutions. The most common violence reported in the study is physical violence, which is initiated by the family and community. Lack of access to health is another form of violence also experienced by transgender women. Most transgender women expressed concern over negative attitudes of community towards them.

However, most civil society sector respondents indicated the need for government to run information campaigns and to educate the masses on various pieces of legislation relevant to transgender women. It is proposed that South Africa has a more progressive constitution and the rights of transgender women should be upheld.
Kapesi Anthony Chakuwamba

Zarina thanked the speakers for bringing back the realities of the environment and for assisting us to understand the terms and challenges experienced by transgender (TG) people, especially the laws and health issues which affect them.

Questions

1. Anthony – you mentioned challenges for TG people. Families and communities have challenges and preaching their rights means there will be attacks – how do they get communities to accept them as fellow human beings and how do they (the researchers) identify the respondents without them being placed in danger?
2. What they need to look at is the shortage of labs in SA – only 2, evidence can take 5-6 years. They can lobby Government to have one lab per province to fast track evidence to improve conviction rates?
3. Services provided by NGOs – what advice do you give to NGOs to work with the system and support the officers who are trying to do their jobs well?
4. Is DNA the only primary evidence that can stand in court – rape is not just about penetration. Many cases are withdrawn because of that.
5. Rollout of specialised courts – what are the chances of rolling them out and of including psychosocial care within the criminal justice system?
6. Concern about the national crisis which is challenged by resources that mean there are not stenographers and that affects and escalates the nature of recordings. Can Lisa say when this will be rectified? They cannot find records often and justice is delayed because of it.
7. Rakgadi – NSP must be taken to the next level, how can that happen?
8. We need to understand the denial of access to medical care; did this relate to them being transgender?
9. Please explain if the process related to a transwoman and did it work out or not?
10. Currently they have a 5-year-old with a transgender issue who is ridiculed at school. DOE has been engaged and bathroom facilities are the concern. There seems to be no way forward for this child.

Answers

Lisa Vetten

As of last year, the Government went into austerity which meant there would be frozen posts. No provincial lab expansion, that simply won’t happen. This all comes to how do they support people who are in the criminal justice system. They have found that good legal support has dwindled, which is an essential role. Organisations must get to know their local court role players, and while this can mean greater work for the NGO, they need to think about this. No DOJ funding currently exists directed toward NGOs; they have some difficulties with the concepts. It is essential that you must show the effects
of what you do – having someone does help reduce levels of anxiety and supports the victims who can become better witnesses. Understand justice when speaking to donors, it is not just about convictions. Get to know the people and assist them and see what can be done. There are preparation officers at some courts but limited; this is a gap and must be dealt with. The more help that can be made available at courts, the better. They need to work in this field and it takes time. They could strengthen the system this way. It is critically important to document the effect of the service. What is ‘the bang for the buck’ to show the value of the services to the system of criminal justice.

Rollout of courts – infrastructure is expensive and so often courts are in the wrong places. What happens is that in very busy courts there is a lack of space. They need to think about a model where no resources exist. How do they improve the system so that the prosecutor is trained and can engage effectively? A system that is less expensive but better. She believed they should challenge the UN and bigger international donors so that the twin causes of prevention and response should not be played against each other when funding is contemplated.

Transcripts – they have lost 80% of transcripts. Level of corruption versus incompetence is not clear.

Anthony Kapesi

It is easy to identify respondents. There are many forums for LGBTI and a lot of civil society organisations and they could identify the sample there. They also determined that they could generalise the findings from the 3 provinces they worked in to the rest of the country.

Child issue – such children are facing a lack of understanding from the school community. There is need for gender recognition policy to be developed at school level. Harassment is the issue which informed our proposal to sensitize the communities. What will happen in future if it is not dealt with now? They must recognise the right of the child to change their birth certificate. This is something they need to emphasise. Where there is a barrier to this, then it becomes more difficult. It is like access to medical treatment, it is a part of transition. This is discrimination as at that point such people cannot have access to treatment. All these aspects are critical. Looking at sexual diversity creates a lot of barriers because of the binary construct of society.

Human Rights as a basis for advocacy – this is critical, they need to understand this. Cultural relativism causes GBV and patriarchy vs universal human rights is an ongoing tension. Nothing should supersede human rights, and this should be part of our discourse within our society. It is analogous to the recent case where child’s rights took primacy over the rights of parents to hit them. Human rights must be supreme.

10:30 – 11:00 Tea
Gender-based violence (GBV), along with poverty, remains among the most pervasive problems confronting women across the globe, with adverse consequences for almost all sectoral areas including agriculture and labour. There has recently been increased attention on the relationship between GBV, HIV and livelihoods. Gender inequality, limited access and control over land, water and other productive resources, lack of access to education and health services, food insecurity, conflict and displacement continue to fuel the vicious cycle of both GBV and Poverty.

GBV and food insecurity also contribute directly and indirectly to people’s vulnerability to poverty and their ability to cope with the infection.

Domestic Violence, Intimate Partner Violence, Dating and Sexual Violence are costly and pervasive problems in South Africa and worldwide. Causing victims, witnesses and bystanders in every community to suffer incalculable pain and loss. In addition to the lives taken, and injuries suffered, partner violence shatters the sense of well-being that allows people to thrive. It causes health problems that last a lifetime, and diminish children`s prospects in school and life.

The United States has made progress in the last few decades in addressing this violence, resulting in welcome declines but there is more work to do to implement the strategies that hold the most promise. This includes teaching the next generation that violence is wrong, training more health care providers to assess parties for abuse, implementing workplace prevention and victim support programs, and making services available to all victims including immigrants and children who witness violence.
South Africa is rated the capital city of rape and the highest incidents of Gender Based Violence. It is estimated that 45% of women have been physically or sexually abused by an intimate or non-intimate partner. A total of 1018 child homicides were recorded across the country in 2009 alone, with 454 being fatal child abuse cases. The numbers are expected to increase given the current killing of children in the Eastern Cape, Gauteng, Limpopo and slowly cropping up in Mpumalanga.

80% of street based sex workers experienced rape and sexual violence perpetuated by their clients, whilst 46% of indoor sex workers reported being forced to do something by a client that they did not want to do. A correlation between anti rhetoric that sees street based sex workers as a nuisance or threat to public order increases violence against sex work.

The above information demonstrates that Mpumalanga Province is not immune to all the above mentioned social ills which posits the following questions - how is GRIP programming addressing the escalating numbers of gender based violence to key populations, women and children? Does GRIP have innovative ways and linkages in their model of care? How can civil society organisations participate in the prevention of such incidents?

“Siyakuphakamisa” which could be translated to “We lift you up!”

Presentation was the same as the PowerPoint presentation and no additional notes were made.
Utilising Personal Risk Assessment Tools for learning, reflection and exchange on individual and societal attitudes, beliefs and practices, myths, misconceptions and systems related to GBV HIV and AIDS and how they feed into the state response

Thabisani Ncube, AFSA

ABSTRACT

Utilising personal risk assessment tools for learning, reflection and exchange on individual and societal attitudes, beliefs, practices, myths, misconceptions and systems related to Gender Based Violence HIV and AIDS and how they feed into state responses.
BACKGROUND

Gender-based violence (GBV) is a profound and widespread problem in South Africa, impacting on almost every aspect of life. GBV (which disproportionately affects women and girls) is systemic, and deeply entrenched in institutions, cultures and traditions. Moreover, causes of GBV cannot be attributed to a single factor but an interplay of individual, community, economic, cultural and religious factors interacting at different levels of society. These factors range from gender inequalities between men and women, social constructions of hegemonic masculinities, social perceptions of what it means to be a man, normalisation of violence and cultural practices such as lobola and Ukuthwala are discussed in this paper. These issues are our Achilles heel.

Speaking to Jacaranda FM in 2016, Former Police Minister Nathi Nhleko said the data (which will form the evidence base for this paper) indicates that South Africans need to reflect on their social behavioural patterns:

“All it says about us as South Africans is that we are violent, so we have a prevalent culture of violence among ourselves and to deal with this particular problem is not just only what government must do, we have to question ourselves”.

The paper will also discuss how the state’s failure to implement GBV related policies and legislation contributes to the problem and argues that legislation cannot operate in isolation. It is critical that drivers are understood to develop evidence based interventions to address it. It is important that the full context is considered, including how interventions aimed at addressing GBV are implemented and evaluated.

KEY INTERVENTIONS

The personal risk assessment tools for GBV and HIV & AIDS are key tools for reflection on how as individuals and communities through our action or inaction are contributing to escalating violence based on increased incidence of new HIV infections.

Successes

Personal risk assessment exercises on GBV and HIV and AIDS are undoubtedly powerful tools for personal reflection and have led to realisable outcomes in behaviour and attitude change. They have an over 90% effect where they have been implemented such as in Zimbabwe and Uganda which the paper will show as case studies.
CHALLENGES

The tools and exercises for personal assessment do not work in isolation and need other supportive interventions to be effective such as counselling, community dialogues sessions, training of key popular opinion leaders to become role models and advocates for behaviour change amongst many others.

LESSONS LEARNT AND RECOMMENDATIONS

Personal risk assessment tools and exercises at individual and community level have the desired goal of unlocking different perspectives that enable people and communities to change undesirable behaviour, attitudes, practices and systems that drive gender based violence and incidence of new HIV infections.

Notes on PowerPoint Presentation – Thabisani Ncube

Sex Rights Africa Network is a regional network which is designed to discuss the ways in which they tackle this critical aspect of our society. They want all partners to realise the essential nature of these discussions.

‘There are things known and those unknown and in between are the doors of perception” - Aldous Huxley

At AFSA there is a printer and next to it a rubbish bin and clearly the purpose of the bin is to dispose of paper, yet it is used for other things as well. They must trust that people will become the best they can be. This is hard because people don’t come with a manual.

Reference to an advert

This advert was one where gender questions are asked about how girls run. One of the questions was which girls, your sisters, cousins, friends? The answer was always No! It is the ‘other’ girls, not the girls known to the respondents. Perceptions again, versus reality.

Cartoon on the confused society – this is what they call our fragmented interventions, is that bringing the results they want.

Perception is dependent on what is experienced, our lives, our place in society.

Personal risk assessment

Thabisani went through the slide with the group and asked each one to answer privately the questions on the slide and conclude regarding the risks. In our lives there is not much time for reflection but 1 response ‘Yes’ puts you at risk of getting HIV.
What he wanted to emphasise is that spaces for reflection is a part of all our practices – all the values underpinned by perception there is a need to leave time for reflection.

Questions asked and directed at the delegates by Thabisani Ncube:

- Is South Africa a violent society?
- I am violent
- Men are trash
- Women are trash
- Ever been in an abusive or abused relationship?
- Do you drink/smoke leading to intoxication?
- Have you ever forced sex?
- Have your children ever been abused?
- Have you filed a complaint?

Self-reflection is critical when working in this field. As he finished he suggest that all should be keeping up with the latest trends, police services released crime stats for 2016/2017 which are alarming.

Where are you in the greater scheme? It must also be a personal conversation which encourages you forward.
Scaling up intervention to reduce the vulnerability of victims of GBV to HIV and AIDS in Cape Town between April 2016 – March 2017

Isabella Chimatira, MOSAIC

BACKGROUND

Intimate partner violence (IPV) is an important global health issue. IPV may take various forms, including physical, sexual and psychological abuse. Several empirical studies have demonstrated a strong relationship between IPV and HIV infection among women.

INTERVENTION

With funding from the Global Fund, MOSAIC designed and implemented an IPV programme in the City of Cape Town. The interventions targeted: (1) IPV beneficiaries seeking court services; (2) victims of IPV in the community. All beneficiaries are offered HIV Testing Services (HTS). HIV positive clients are referred to the local clinic for CD4 count and initiation of anti-retroviral therapy (ART). People Living with HIV (PLHIV) are also provided with positive health, dignity, and prevention (PHDP) interventions to lead a complete and healthy life and reduce the risk of transmission of the virus to others. Additional interventions included HIV prevention services, STI and TB screening and support groups. Data on beneficiaries of the IPV programme, including demographic details are routinely collected using standardized forms. These data are collated into a database.
RESULTS AND LESSONS LEARNT

Between April 2016 and March 2017, 3,648 individuals received IPV-related services at the local courts and in Wynberg Khayelitsha, Philippi and Mitchells Plain communities. 2,813 (77%) were females and 835 (23%) males. Beneficiaries targeted included: Young women and girls (14-24 years) = 388 (11%); Injecting drug users= 64; LGBTI= 16; MSM=3; Sex Workers= 16. The forms of IPV experienced by the program beneficiaries included: emotional abuse 3,335 (91%); physical abuse 2,494 (68%); economic abuse 1,337 (37%); and sexual abuse 842 (23%). 1,206 (33%) were tested for HIV and received their results, 956 (26%) were women and 250 (7%) were men. 105 (3%) of the victims of IPV were living with HIV. 16 (1%) were successfully referred for ART as confirmed by client. Clients did not come back with feedback on confirmation of successful ART referral. Those that tested HIV positive were 297 but new HIV infections were 285 as 12 were already living with HIV. All the clients who had an HIV test were screened for STIs and TB. There was no positive TB and STI screening.

Buy-in from DOJ was key and critical to enable us to test beneficiaries at the courts as we were not allowed to test at all courts except Khayelitsha court. We had to strategize to have IPV workshops and support groups as follow up sessions to enable us to test clients who did not get a test at first encounter. Because of missed opportunities to test clients at sites and courts at initial encounter, there is need to have strong referrals for HIV testing with partners and health care workers to avoid missed opportunities for testing. Successful implementation of IPV programmes requires stronger collaboration of multiple stakeholders to ensure positive feedback on successful referrals.

CONCLUSIONS

The project shows that with political and stakeholders’ will, districts can work with partners to develop GBV-related interventions for a more effective, wider scale up.
The Use of Counselling to Curb Domestic Violence
Prisca Goremusandu, Khuluma Family Counselling

BACKGROUND
Being an African woman staying in Africa the writer has learnt that there are many issues that affect the African woman regardless of where in Africa she comes from. The African woman’s socialisation has taught her that she does not speak to a third party about her domestic issues. She will only speak to family members and usually it’s the husband’s relative who may even turn out to be supportive of the abusive husband whether he is right or wrong, this is done mostly without checking for facts from the woman. Counselling, although it was being spoken about in the communities, not many people wanted to come out in the open to say they had been for counselling. It was considered a private affair where even the spouse of the survivor would not be told.

COUNSELLING AS AN INTERVENTION
According to the American Counselling Association, professional counselling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals. Counsellors work with clients on strategies to overcome obstacles and personal challenges that they are facing. Counselling has become an integral part of solving domestic violence issues. Women have secretly referred each other for counselling. They do it secretly because they are afraid of being labelled within the community or their husbands finding out that they had been for counselling. If found out this would bring further challenges for them. Out of the counselling sessions women have been encouraged to speak out and encourage other women to share their stories. Two women were picked out of those who came for counselling and taken to a one-week long workshop where domestic abuse stories were shared through a life line.
Successes

The women who were involved in the week-long workshop were so inspired that they vowed to help other women who are in the previous position before counselling. These two ladies are now ambassadors who stand in front of crowds and denounce domestic abuse. The two women have started publicly sharing their life stories and how counselling equipped them. With the assistance of the counsellors and social workers within the writers’ organisation, Khuluma Family Counselling, support groups are being formed to help more women with awareness talks. Some women decided to leave their partners since they realised that there was no reason to remain in an abusive relationship.

Challenges

Most women are afraid of their partners hence the silence.
Names given to some support groups are stigmatising.
Addressing people in a group without addressing them individually destroys the purpose of forming the group.
Women cannot take part in the programmes if they are not empowered to have a life outside their current relationship.

Recommendations

- Encourage seeking for counselling through awareness campaigns
- From the individual sessions encourage the use of psychoeducational and skills development support groups to help the abused speak, decide and act on their situation
- Give encouraging names to the support groups
- Facilitators to continuously support the groups
- From the support groups form income generating projects

The presentation was the same as the PowerPoint presentation and no additional notes were made.
INTRODUCTION

South Africa has some of the highest incidences of rape in the world therefore it is no surprise that its correctional facilities are also besieged by this phenomenon. Rape in prisons, including in all “male” facilities, is undergirded by the same patriarchal principles that inform rape in broader society. It is for this reason that JDI-SA developed the “Let’s End It Now! Fighting Rape and Promoting Health in DCS Facilities” programme currently being implemented in South African prisons to assist DCS staff with strategies, resources, skills, and tools to implement the “Policy to Address Sexual Abuse of Inmates in Department of Correctional Services Facilities” of 2013 (Sexual Abuse Policy). It aims to make correctional and remand facilities safer by transforming the deeply rooted culture of violence, and specifically sexual violence, which are underpinned by hypermasculinity and misogyny.

BACKGROUND

The Sexual Abuse Policy came about because of years of collaboration between JDI, the Centre for the Study of Violence and Reconciliation (CSVR) and the DCS in a bid to address the historically ignored and rampant issue of sexual violence taking place in South Africa’s prisons. This partnership with DCS is important because when a person is arrested, the government becomes fully responsible for their safety. It is JDI-SA’s core belief that no matter the crime committed by an inmate, rape is not, and should never be, part of the penalty. Not only does that violate their rights to safety, dignity and good health, but it also endorses systemic oppressive structures such as patriarchy and its attendant ills. To that end, the programme has the following objectives:

1. To generate a zero-tolerance culture towards sexual abuse in DCS facilities.
2. To build DCS officials’ understanding of the dynamics of sexual abuse in DCS facilities and its impact on survivors of this abuse, as well as on broader society.
3. To establish facility-level leadership committees to spearhead implementation of the Sexual Abuse Policy.
KEY INTERVENTIONS

Having worked with DCS to develop the Sexual Abuse Policy, JDI-SA conducted years of advocacy to get the policy adopted, and then to get implementation started. JDI-SA is assisting DCS to roll out the programme through training staff, building staff based committees to lead on implementation, and offering ongoing technical support.

SUCCESSES

• Sexual Abuse Policy developed and adopted
• Pilot programme implemented in Leeuwkop Correctional Centre
• Partnership with National DCS established to conduct programme in all its management areas

CHALLENGES

• Getting policy adopted, and later, implementation going
• Getting buy-in and commitment to the process from DCS officials
• Sometimes strained relations between DCS and other partners affected JDI-SA’s relationship with DCS

LESSONS LEARNT AND RECOMMENDATIONS – DOREEN GAURA

• Partnerships are key, if not always easy
• Need to unpack gender and sexuality with training participants to open way for discussions on prisoner rape
• A multipronged approach is necessary when dealing with various stakeholders
• Flexibility and a willingness to adapt is key

Her organisation is still young in SA and has only just embarked on its interventions and therapeutic journey. Please view the presentation in that light.

The work is linked to a DCS draft policy which is where the programme comes in. The policy was approved in 2013 but is yet to be implemented.


The work is mostly training staff and they will move on to working with inmates shortly. This is so that there is a framework that inmates can use to access their rights when that training does take place. Majority of the population in prisons is
marginalised and poor. It is a most violent system and most prisoners are violent themselves. Prisons are overcrowded with averages of 100 people in cells designed for 40 people. This reality highlights the challenge to address GBV and violence within prisons. They work directly with government as the helpful advocate, will look elsewhere if this relationship is not successful.

She then went through the PowerPoint which was the same as the presentation and accordingly no additional notes were made.

Questions

1. I see that your counselling system is mostly from an American context, how does it become culturally relevant especially in the black skin?
2. How do you find a solution-focused treatment therapy when the victim will inevitably be returned to the same environment?
3. Doreen, why are you focusing on men in prison when women in prison experience the same and continued levels of violence as well?
4. Doreen, what are you doing as an organisation to look at the rights of women? Where do you operate?

Answers

Prisca Goremsandu

They did use American definitions for this presentation. A client once said that she never thought counselling was for black people and she was very upset, and they could see that the socialisation they have had that made them think like this. They never had access to counselling – they were just given advice by grannies. Most of the literature is not accessible or even exists, the content is not always available in the languages. Point is well taken however, they should always contextualise our context and go out of our way to seek it. It is one of the challenges which they are addressing in their work. [www.khulumafamily.org.za](http://www.khulumafamily.org.za) is the website and she said are all welcome to refer clients to them. We need to #enditnow.

Doreen Gaura

Realities are important to bear in mind – they do focus their work on a holistic approach and the policy looks at all the factors that make for a success, this includes the things that make people more vulnerable. Screening will help to protect vulnerable groups from being placed in threatening places and look for less threatening places for them. Looking at addressing overcrowding; people are held in cells 23 hours a day because of understaffing. The DCS recently launched a new programme that works with
perpetrators of sexual abuse. Although this links to their work it is not done by them. As mentioned at the beginning, they have not yet started working with inmates, they are a new organisation. This is also why they are working in male prisons. This was the basis of their starting with the work. JDI is an international organisation that was approached by male warders in male prisons. They were overwhelmed and JDI started working with them to facilitate their work. The programme then expanded, and is still expanding, nationally. The plan is to go into all places of detention and access although is difficult, it is matter of capacity and access will happen as they continue with it.

Pilot project was in Leeuwkop and DCS have asked them to do training in 9 further facilities. They are rolling it out incrementally.

Venessa commented that there is a detention justice forum which NICRO works with and they have made the link. They work with clients who have been referred to partners within the groupings.

Additional comments by delegates

We affirm Thabisani and his approach. It is critical to reflect continually, so that when politicians comment on issues, for example ‘that is why we have violence’, forgetting the cultural impact and structures that contribute to it, we can reflect critically. The work in prison is critical to help us grow a just society.

I understood prison to be rehabilitation and yet people are dehumanised there. Is there hope for holistic healing? We are human beings and we need to treat everyone as such. We must remember this.

The data done by Mosaic is rich, but the new infection rate was 8% - the total number of people is closer to 30%. We implore people to bring us their statistics and information so that we can advocate for IPV work as an HIV mechanism.

We once worked with a HRSR programme, we still need it; the need is so great in our areas. New information on HIV has emerged and the stats are frightening. We need the programme to continue everywhere.

Question on the stats – I would like to see the figures disaggregated into males and females and would like to know how the programmes capacitate the persons. Research needs to be action based to make a difference to the lives of the respondents.

A vulnerable group which has been omitted is an inmate who has no outside resources as they tend to rely on other inmates for these and can be prey to additional victimisation.
Civil society must continue to document the work we are doing as there will be less effect unless we show that what we do here is making a difference.

Venessa then finalised the discussions by saying that they must translate this knowledge into work and they must do it, not just say it. She said Thank you for the work of all of us. Collaboration and partnerships are very important they cannot do it all, but they can support each other in a team. She said that she invited all to look at stigma index on the SANB index – it is everywhere, it all begins with you and me. Perfect time to end it is now. We can #enditnow.

She asked the delegates present to please complete the evaluation form to give all the organisers input and feedback.
Never your fault: South Africa’s response to IPV in the context of HIV

Dr Samu Dube, AIDS Legal Network

Session 1: Dr Samu, No PowerPoint. South Africa’s response to IPV in the context of HIV

Breakaway 3: Exploring South Africa’s Response to IPV and Rape in the Context of HIV

It is difficult to negotiate our worth as NGO service providers with donors. The intersection between GBV and HIV causes us to choose what services we offer and who will pay for these services and who will we approach for funding. We want to empower women, understanding that this is the most powerful way to approach this intersection. We believe that this is key to improving the economy, especially with the slowing of macro-economic growth. So, who is going to pay? Most new HIV infections are coming from young women and girls living in informal settlements.

But Donald Trump has said Africa should look elsewhere for aid and not to the Global Fund, UN AIDS and USAID. Prevention of HIV starts with condoms, HIV counselling and testing, behavioural interventions, biomedical interventions such as male circumcision, microbicides, PrEP and PEP. A government can implement such interventions but the responsibility rests on the individual. A government can cost these interventions. But at the end of the day sex is an impulse, an impulse not conducive to these kinds of premeditated interventions – the science is beautiful, but it is not practical.

The narrative about prevention needs to be grounded in the social infrastructure and how that needs to change and move away from clinical trials. What would investments in social infrastructure do to change the HIV landscape? If you increase
the number of years a girl stays in school, you are increasing her chances for economic advancement and decreasing her chances of getting HIV/AIDS.

When resources are scarce, as they are now, they should be lobbying government to offer a minimum package of care and enhance social cohesions via community strengthening. They need a multi-sectoral approach that includes things like housing and education and not just behaviour change. Civil society needs to be accountable for this shift in the narrative and make demands of donors that looks at the marathon and not the sprint. We need to invest some of our money in social infrastructure. Let us work on developing innovative financing mechanisms for HIV prevention.

How do they rope in big business to invest in this kind of change? How do they show them the cost benefit?

ADDITIONAL NOTES

Presentation focused on the uncertainty of funding, who should pay, and how much to pay.

Based on the budget speech yesterday, the economy is in a deficit.

Interlinkages between GBV, HIV and the economy – young women who are living in informal settlements. Spoke about the fragmentation of donors with reduction in spending by US government.

How much will HIV prevention cost? Some stats provided on the cost of different interventions, and inform models of care. Not all prevention methods are workable/practical, for example gel.

Let’s change the narrative. Where should they put resources and investments? What social infrastructure should they invest in? How do they invest in women?

CALL TO ACTION

1. Narrative of economic development
2. When resources are constrained they should implement a minimum package of services
3. Community systems strengthening – increase social cohesion which will improve HIV prevention
4. Other development e.g. housing
5. Behaviourists e.g. vaccines are good but think of the bigger picture
6. Civil society: invest in innovative financing, be accountable for the funding
7. Donors: invest in social infrastructure to create an enabling environment for women to be empowered
8. Who is going to pay? They need innovative HIV prevention programmes and to promote economic development
Thuthuzela Care Centres as a model for reducing GBV and HIV

Nomnqweno Gqada, Rape Crisis Cape Town Trust

BACKGROUND

The TCC model was developed by the National Prosecuting Authority’s Sexual Offences and Community Affairs (SOCA) Unit to reduce secondary victimisation of rape survivors, increase the conviction rates of rapists and reduce the length of time taken to finalise rape cases in court.

The Rape Crisis Cape Town Trust has been providing services in two TCC situated in Bellville and Mannenberg for the last 6 years. Their aim, more specifically than the TCC model, is to minimise the impact of the rape in terms of its medical risks and further emotional trauma.

KEY INTERVENTION

Trained lay counsellors, supervised by a registered social worker, offer crisis containment to rape survivors immediately after the rape at TCCs. The counsellor explains the potential risk for HIV and why HIV testing and adhering to prophylaxis is so important. Those who are already HIV positive are referred to nearby clinics. They inform survivors of their rights within the criminal justice system and give them a care pack containing toiletries, clean underwear and an information booklet so that they can wash, change into clean underwear and read up on CJS procedures and process of healing after rape. Reducing the secondary trauma of survivors at this early point in the process increases the likelihood that they will remain in the system and take their trial to completion and that they will return for their follow ups and complete their medication.

SUCCESSES

We are providing a service to 2500 survivors per year at these two centres, 33% of whom are between the ages of 14-24. This group represents a high-risk group for gender based violence, which places them also at greater risk for HIV.
characteristics also increase the chances of HIV infection; 18% of the rape survivors we encounter were raped by more than one perpetrator, some by as many as nine. An average of 89% of clients are tested for HIV at these centres; 90% of these test HIV negative, and 68% of those are in time to receive PEP.

Our counsellors play a critical role in encouraging testing and adherence to PEP. Many clients are reluctant to disclose their status or do not wish to be tested for HIV; this is especially so for parents accompanying a child. By explaining the risk for HIV and how PEP mitigates this, and how important ARV treatment is for already positive people, survivors and parents more readily consent to testing and treatment. The relationship they establish with the client also increases the likelihood the client will return for follow up testing and complete their medication, especially when we have access to telephones and are able to call clients who do not arrive for their appointments and assist them with any issues relating to PEP.

**CHALLENGES**

One of the largest challenges we face derives from the lack of coordination amongst the different stakeholders within the criminal justice system, which negatively impacts on service provision. At a site level we see this in protocols being implemented differently across sites, lack of role clarity, inconsistent referral procedures and feedback. Without a good relationship with these stakeholders, we cannot track outcomes for our clients.

**RECOMMENDATIONS**

We would recommend that the State continue to see TCCs as their preferred response to GBV and HIV and that the model is written into legislation. Furthermore, role players need to mobilise the necessary funds to ensure the sustainability of the TCCs and their impact on reducing HIV incidence and GBV.

**NOTES**

Rape Crisis works in three different sites at Karl Bremer Hospital and Heideveld Health Care Centre as well as at Victoria Hospital which is not a TCC as the NPA is not there. These centres see over 3 000 cases per annum however this represented only a small percent of the rape survivors in the city, many of whom are unable to access these services. At the TCC they hope their efforts will lead to the eventual conviction of the rapist and that they will ensure they don’t incur further health risks.

Almost 90% are women, while just under a third of these cases represent young women and girls. 64% of rapists are known to the survivor, who often are dependent on them sometimes even as their intimate partners. It takes enormous courage for
these survivors to come forward and report abuse.

Nomnqweno described the services offered by the counsellor of first responder at the service, emphasising the importance of psychosocial care in addressing the trauma experienced by rape survivors. Showed photographs showing the faces behind the service and the dedication of personnel.

Rape is a serious risk factor for HIV transmission, and Rape Crisis believes the TCCs are an effective model for addressing this risk, as psychosocial care enhances adherence. It also reduces secondary trauma and makes a significant difference in keeping rape cases within the criminal justice system.
PEP: Interventions that enhance adherence

Fiona Dama, TVEP & Martha Radebe, Ekupholeni Mental Health & Trauma Centre

NOTES

- TVEP opens 120 - 200 IPV cases per month
- 40 sexual offences cases
- 10 -15 severe trauma cases

PEP compliance is up and down as staff capacity at TVEP goes up and down but on average it sits at 85%. This is because of personalised case through a buddy system using victim advocates if the client needs help. They offer trauma containment, do home visits to follow up on family circumstances within three days and after 28 days as clients do not have access to transport to come back to the trauma centre. They provide anti emetics to deal with the side effects of PEP and they also give them E-Pap to mix with water as food to take with their medication if they don’t feel like eating.

We need to do campaigns raising awareness on what reporting to the criminal justice system involves and how to access PEP as an important component of HIV prevention post rape and how to access these services.

Ekupuleni is running a service at the TCC at Thelle Mogoerane Regional Hospital as part of a multidisciplinary team. There was very little space initially but after strong advocacy space was given to each stakeholder. NGOs strengthen the medicolegal response to rape by offering psychosocial care.

When NACOSA began to offer funding in 2013 their goals, indicators, targets and methods of verification their focus was on PEP adherence. They looked at offering PEP in a way that acknowledges the context of rape survivors, offering a full course of medication at the first visit with a full list of written instructions and suggesting they find a trusted person to support them in taking their medication each day. They follow up with clients at three weeks, six weeks and four months. They developed satellite clinics to make the follow up service more accessible to clients and social workers at these clinics offer psychosocial care as well. In this way families and the broader community help first responders and enable clients when it comes to adherence. Ekupuleni also go onto local radio stations to speak about PEP.
Critical Questions: The role of NGO services at TCCs

Shukumisa Coalition

A Critical Assessment of the Role of NGOs in the Delivery of Services to Sexual Gender Based Violence Survivors at Thuthuzela Care Centres

In 2017, the Shukumisa Coalition commissioned a study to better understand the role played by Non-Governmental Organisations (NGOs) who work in Thuthuzela Care Centres (TCCs) and the challenges that they face. TCCs are one stop shop facilities that provide medical and forensic services, psychosocial counselling and prosecutorial services to victims of sexual gender based violence. The intention is to offer an integrated service from emergency trauma care to preparation for court, ideally reducing the overall length of time in finalising cases and improving conviction rates. The psychosocial services are offered by NGOs. Although without them it would not be possible to offer 24-hour services to victims, they do not currently form an integral and essential part of the TCC Blue Print or model and therefore are required to source their own funding to enable them to deliver these essential services.

Qualitative data was collected from 19 NGOs’ key informants through face-to-face and telephonic interviews following a structured questionnaire and a consultative forum that brought all NGOs together. The results showed a myriad of successes and innovative practices instituted by the NGOs to advance the well-being of, and restore justice to SGBV survivors. However, numerous challenges were also cited, relating to both conceptual, operational and institutional arrangements in the TCCs.

The findings of the report relate to the extent of SGBV and systemic under reporting, the efficacy of the TCC model, the quality and standardisation of services offered by NGOs, the funding and sustainability of NGO services in TCCs, the challenges faced by NGOs and the policy implementation gaps.

The consultative forum provided room for engagement for the NGOs to formulate recommendations, which included that NGOs should lobby government to develop
a legislative framework to allow for the establishment of TCCs as a formal part of the criminal justice system and putting in place a sustainable funding model for NGOs and TCCs in general.

The Shukumisa Coalition recognises the urgent need to take this study further as the level of frustration of NGOs working in TCCs is mounting. Many of the organisations took part in various studies and attended numerous meetings over the past few years to explore how to improve their role in successfully fighting sexual violence, yet the challenges seem to remain the same.

The next step to take for the Shukumisa Coalition and the NGOs who formed part of the study, is from recommendations to strategic advocacy actions.

Critical Questions: The role of NGO services at TCCs – Kathleen Dey, the Shukumisa Coalition

1. There is a lack of funding for GBV now. How do they work towards domestic resource mobilisation and not allow international donors to dictate? Also, our government is unlikely to fund this. How do they advocate for this?

2. What about the intersectional nature of GBV and HIV and foreign or migrant women from other parts of Africa? Can they approach those embassies to fund some of these services?

3. How can they showcase and highlight their successes in the media? How do they show the value of their work as rand or dollar amounts especially when it comes to salaries and care work done predominantly by women?

4. We cannot look for funding for prevention when the funding for psychosocial care is at risk. What they can do is look for funding for GBV through making the links with HIV.

5. We have a lot of challenges with working in a multidisciplinary team. Can Shukumisa resolve these?
Session 2: TCCs: working in 3 different TCC sites; Karl Bremmer, Heideveld CHC and Victoria Hospital.

There is an elevated risk for young women and girls. Their expectation is that the perpetrator will be arrested and that they will get loving care at the TCCs. It is a very scary experience. They are in their reproductive years.

Violence perpetrated by people you know and depend on. Also see foreign nationals and a client reported her husband who is abusive to her and her 4-year old child. It was hard for her to leave because she doesn’t have anyone she can go to for support, and is not sure TCC would believe her story.

The counselling room must be a safe space and have rooms where children can play.

Sister – with comfort packs: face cloth, soap, toothbrush etc. On Mandela day drive and distributed 1500 care packs.

Session 3: PEP intervention

In 2013 there was a drop in reported cases. Is this because things are working and there are less cases?

PEP compliance has mostly improved. Reasons for ups and downs – staff resign.

Average compliance is approximately 85%. How are they doing it? Personalized care.
PEP interventions to enhance adherence

Martha Radebe, Ekhupuleni.

There is no PowerPoint associated with this presentation.

Organisations started due to elevated levels of violence in their area. There was lots of sexual abuse. The DSD asked them to start a crisis centre and subsequently a TCC was started and they became involved in the TCC. In 2014/15 the TCC had no space for all team players. Civil society was given a space to render services and it was a one stop centre. A space was created through advocacy.

The role they can play:

- Given medication: antibiotics, PEP (56 tablets), emergency contraception
- Need to complete the course but people do stop as they feel better

NACOSA came with a programme that was slightly different to the DSD. One issue was to improve PEP outcomes, to be tested and to know their status. They also focused on people who are HIV negative. They write the client a letter documenting everything they have received at the TCC and providing guidance for adherence. They request a person to be a buddy for the client. The buddy conducts home visits to make sure they get support. They also assess whether they have food to assist with adherence and they also phone clients to maintain contact. They record all contact sessions. NACOSA verifies this quarterly. Adherence has gone from 4 to 130 through these measures.

They make sure the client comes to all follow ups to make sure they remain HIV negative.

They also follow up with other clients who may not be given PEP.

They set up satellite clinics to help with follow up.

30 clients initiated on PEP and defaults are between 2-4 people per month. The key role of family highlighted for adherence. All staff are available to support: social auxiliary workers, social workers etc.

NOTES

Precarious situation as TCCs are not legislated.
Model is hard to prove the efficacy of the intervention because follow up on patients is hard.

Open discussion:

- Funding in general
- Funding prevention vs care

**QUESTIONS**

1. GBV work is funded by outside donors and why not domestically? They need to advocate for prevention technologies. How do they empower communities to understand prevention technologies?

2. Women & diversity: especially migrant women. What about approaching embassies towards these services? Creative ways to generate income. As organizations they fail to showcase their successes. They need to start thinking about how they monetize their work and use this as an argument to motivate for funding. Don’t want to perpetuate ongoing situation of women earning low salaries for their work in the GBV space.

3. Services after the fact or on prevention: need to have both. Various kinds of prevention and see care as preventative as well. E.g. mental health support can prevent long term care.


5. Success of the work lies on the multi-disciplinary centres and the success within TCCs themselves. Can Shukumisa assist in working relationships within the centres?

**ANSWERS**

**Dr Samu**

1. Scholarly work is there to show the link to health and GBV. Also look at the economic cost of GBV.

2. How do they become sustainable long term?

3. Donor community: they are partners. What do partners want out? Change the way they see donors and NGOs.

4. NGOs: prevention is important and there is a lot on the go so they should use partnerships for HIV prevention.
Kath Dey:

- What can they do to raise funds? Use the media – showcasing will be a good strategy.
- NGOs to try and change the culture of TCCs to be truly multi-disciplinary.

Additional notes on the responses:

Dr Samu, how do they represent our work in a way that shows empirically the link between mental health benefits and the empowerment of women with reductions in HIV prevalence? There is no shortage of scholarly work on this and there is no doubt that they need to advocate for funding using these. What is the way of becoming sustainable long term, perhaps as social entrepreneurs? Can they commercialise some of our work? The challenge to the donor community is that they are partners and they would want a return on investment. What return are they going to give them? How do they find innovative ways for funding social infrastructure? The African Development banks need to come to the table and offer funding for safer environments.

Kath Dey: at this moment they are not showing the current donor that they are making a difference as far as PEP is concerned and that puts our funding at risk. The culture of a multidisciplinary team is different from the culture of a health facility. They need to ensure that they explore and define this new collaborative culture – as a sector as much as in the TCC.

13:00 – 14:00 Lunch

14:00 – 14:45 Interactive Resolution

Phumeleo Ncube thanked the delegates and took them through the Clauses to explain and ensure all had heard them.

Maureen thanked all for their inputs.

The national conference to promote linking, learning and action on the state response to gender based violence (GBV), the interaction between HIV and GBV and the impact of GBV on young people – End it Now! Together in Response to GBV and HIV – issued the following resolution:

The assembled delegates,

Recognising the extent and severity of GBV and HIV in South Africa,

Understanding the links between GBV and HIV and the burden that falls particularly on young women and girls,
Acknowledging the importance of a strong collaboration between government actors, local and international donors and civil society organisations,

Celebrating the very real success of current best practise multi stakeholder models at alleviating the extreme suffering of survivors of GBV, supporting recovery, and ensuring access to justice and to health,

Affirming that changing patriarchal attitudes and norms associated with GBV and HIV is a necessary intervention, and

Convinced of the preventive role of psychosocial care in ensuring a decrease in both GBV and HIV,

- Requests all organisations represented at this conference to intensify their efforts to lobby state role players to place services aimed at survivors of GBV that include access to HIV testing and Post Exposure Prophylaxis (PEP) high on the political agenda;
- Encourages all organisations and practitioners in the sector to intensify their efforts to work together and share best practice models for delivering services that deliver tangible outcomes to survivors of GBV;
- Encourages organisations in the sector to facilitate and support conversations and dialogues on the issue of changing harmful social attitudes, norms andbehaviours that promote GBV at every level of society.
- Urges increased solidarity between organisations in the sector in engaging in taking collective action to mobilise support for services to survivors of GBV;
- Calls on the South African government to ensure formal policies, plans and budgets and a multi departmental approach to ensure the ongoing delivery of psycho-social services to survivors of GBV that include access to HIV testing and PEP; and
- Calls on both foreign and local donors, specifically AFSA and NACOSA as grant managers and the Global Fund to continue funding the ongoing delivery of services to survivors of GBV that include access to HIV testing and PEP beyond March 2019.

On behalf of the task team, Venessa then thanked all who made the time to be a part of the proceedings. She thanked them for sharing their inputs, for being brave and sharing what was on their minds, and noted that all participations were a success. She added to the survivors: ‘statistics have a face when a person tells a story that moves and inspires.

She thanked the colleagues from Conference Call who played their part efficiently and professionally, she noted appreciation for the work they did.

She thanked all who made the arrangements and said thank you personally to Sharon Kouta who, even having had to face personal tragedy, none-the less persevered in her tasks of arranging the conference.

There being no other work or comments, the conference was declared closed, all participants and delegates were thanked and wished a safe journey home and strength in the battle to #enditnow.
At the end of the End it Now! Together in Response to GBV and HIV Conference organized by NACOSA and AFSA and funded by the Global Fund, participants were asked to complete a short online evaluation. The results of the evaluation were positive with 86% rating the conference either very good (35%) or excellent (51%) overall.

A total of 51 people completed the evaluation out of 250 participants, representing a response rate of over 20%. The vast majority were from the NGO sector (86%) with just 6% from government and 4% from business. Most found out about the conference through their network (44%) or by email (28%).

**Q3 How did you find out about the End it Now! Conference?**

The content elements of the conference were all rated similarly well (either good or excellent) with Programme direction receiving the highest score (weighted average of 4.4) and Panel sessions receiving the lowest (weighted average of 4.12). In terms of the logistical elements of the conference, Accommodation received the highest rating (weighted average of 4.74) and Communication from organisers received the lowest (weighted average of 4.32). Again, all logistical elements were mostly rated either good or excellent.

When asked which sessions were most useful, some respondents mentioned plenary sessions and the survivor stories. A number of respondents said all the sessions were useful.

“The survivor slot, when they shared their personal story that sounded scary but true. It made me realize the problem is huge and we must end it now.”
“All sessions from day 1, especially the brake away sessions, it gave more time to engage with each other.”

“To be honest, all the sessions were excellent.”

“Where participants tell their own stories to indicate how they survived and are fighting to not be demoralised.”

“They were all useful – I especially liked Lisa Vetten’s presentation.”

“The media session.”

When asked what the least useful sessions were, many respondents said none. Least useful sessions that were mentioned were the interactive resolution, the plenaries, the ukuthwala presentation, the faith session and the NSP for GBV session.

“I’m totally impressed with everything.”

“I) some presentations were very long, 2) the ladies from Soweto sex workers repeated the same presentation and spoke about the same things all over again.”

“The faith session; I think it would have been useful if it was presented by someone from the faith section.”

Almost all respondents (98%) thought the conference provided them with learning, sharing and networking opportunities.

Some of the suggestions and recommendations from respondents include:

“Next time to please be inclusive, conferences like these where we deal with issues that affects the whole community need not be about politics and positions those do not matter what matters is the fact that people are dying.”

“There were some topics in the breakaway sessions that I felt could have been repeated, as it meant choosing and missing out on information.”

“Would like to see different Government officials e.g. DSD, DOH, DOE, SAPS being present as they play vital role within different programs rendered at community level.”

“The conference lacked a clear aim of how we were going to end GBV. With the room full of potential, it was a sorely missed opportunity to make collective actions and commitments.”

“The conference was excellent. It was such a massive exposure. It was bringing insight as to what is happening to women throughout our communities. I wish much platform was given to the participants or different organizations that were present to also express their views to share their success and their challenges in this regard.”

“It should be done at least twice a year.”

“I would suggest a call to be put up in order to get a variety of abstracts, because for now even though content was good issues of rape dominated the conference. We understand that rape is a huge problem in GBV but it’s not the only violence women experience in the hands of men.”